INTERAGENCY MEASUREMENT OF CHILD WELL-BEING

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Improved coordination and collaboration among the government agencies that promote the well-being of vulnerable children is one of California's top priorities. These efforts recognize that the needs of children are not compartmentalized, but span the breadth of services and supports provided by the State.

The safety, permanency, and child well-being indicators developed by the California Health and Human Services Agency (HHSA) *Child Welfare Outcomes and Accountability Workgroup* were designed to measure multiple life domains using the Child Welfare Services/Case Management System (CWS/CMS), and were to be consistent with the requirements of Assembly Bill 636 (AB 636 -Steinberg). AB 636 provides a framework for action toward accountability, requiring HHSA to establish a plan by which outcome-based reviews would be conducted in all counties by the California Department of Social Services (CDSS). The difficulty inherent in such an effort arises from the fact that the CWS/CMS system is a case management system and was not designed to produce outcome data. The data systems of other state agencies were also, for the most part, not designed to produce outcome data or with data sharing explicitly in mind. Achieving the State's ultimate goal of addressing these well-being indicators accurately and efficiently will therefore require a long-term effort.

Although the development of the well-being indicators proposed by the Workgroup has continued through a specially formed CDSS AB 636 subcommittee, it has become apparent that simply utilizing CDSS's CWS/CMS will have its limitations. For instance, the Workgroup sought to determine whether children involved with child welfare services (CWS) were assessed for, or received, special education services. Although CWS/CMS has the capability to capture this information, the reliability of those data is questionable due to variations in individual county's requirements for the completion or updating of the data elements. Therefore, utilizing educational data in combination with what is contained in CWS/CMS could provide for more enriched educational information.

As a result of the desire to continue developing the well-being indicators established by the Workgroup [and in response to the recent federal Child and Family Services Review (CSFR), the Legislator, and various stakeholders], the *State Interagency Team (SIT)* charged CDSS with coordinating the analysis of the key data systems of the relevant member state agencies. With the assistance of appropriate staff from those agencies, CDSS's primary objective was to identify the potential for using these data systems to augment and/or validate AB 636 reporting. In April of 2006, CDSS made a formal request to the University of California, Davis's *Center for Public Policy Research* (CPPR) for technical assistance on this project. CPPR was officially contracted to perform the following functions:

- Assess possibilities and make recommendations for integration and shared data management among state agencies to better realize AB 636 outcome measures.
- Investigate and propose opportunities for data integration and utilization.
- Identify other information available on AB 636 issues

The current report serves as a summary of findings and recommendations stemming from these investigations.

Findings

At the outset of this project, CPPR was provided with a list of 15 well-being indicators developed by the Workgroup. For purpose of analysis, CPPR broke down these indicators into 33 distinct outcome measures. It is this list of 33 outcomes that will be referred to throughout the report.

In summary, CPPR has determined the following:

1. Data are available within CDSS or other SIT member agencies to adequately address 18 of the 33 outcomes.

2. Data are available within CDSS or other SIT member agencies to partially address 4 of the 33 outcomes.

3. Data are not available within any of the state agencies investigated by CPPR to address 11 of the 33 outcomes.

Many of the indicators are related to data collected by CDSS's CWS/CMS system, whereas a large proportion of the remaining variables are related to health and education services provided by the Department of Health Services (DHS) and the Department of Education (CDE). It was clear from discussions with agency staff that data are available; however, they are not always available at the child level, but rather at higher levels of aggregation.

In terms of DHS, a significant proportion of health-related outcomes are particularly relevant to the database maintained by the *Child Health and Disability Prevention* (CHDP) program, which ultimately feeds into the Medi-Cal Eligibility Data System (MEDS). DHS representatives expressed a strong desire to work with CDSS, not only in relation to CWS children, but to the broader population of Californians served by both departments.

CDE also houses data related to many of the well-being indicators and is eager to work with CDSS—in large measure due to their own desire to locate and track foster children in their data systems. If CDSS could provide CDE the information necessary to do this, CDE could, in turn, provide the data needed to address a number of the education-related indicators.

Each of the other departments with which CPPR met not only expressed support for this project, but house data that could prove relevant to AB 636 issues. As will be seen throughout this report, those data are primarily related to indicator 7A (support services), which was written to be broad and inclusive. Following future clarification of this indicator, the data held by other SIT member agencies may prove more or less vital to CDSS's mission.

Finally, although further details can be found in the body of this report, it will be noted here that issues related to data integration and confidentiality were also discussed with all departments. Such issues are often described as "road blocks" to the sharing of administrative data between government agencies. It is CPPR's belief, based on our research, that these difficulties are not insurmountable. All of the key databases CPPR located contain adequate

demographic information to perform probabilistic matching (even without the existence of common unique identifiers), and there are several ways to approach legal barriers related to confidentiality. Internal merging and de-identification can be performed prior to data release to CDSS, contracts or Memos of Understanding (MOUs) can be set up between CDSS and other departments, or analyses can take place within other departments (e.g., DHS) and CDSS can then be given analysis results rather than raw data.

As any of these approaches will require a fair degree of time and human resources, the next step for CDSS and other SIT member agencies is to reach an agreement on where those human resources will come from, what current or future personnel would be needed, and whether further funding will be necessary. Addressing the AB 636 indicators *once* will require a certain degree of commitment; setting up a process by which the tracking and sharing of data related to CWS children can take place regularly, efficiently, and more thoroughly than possible at the present time will take a long-term commitment from HHSA and several of its constituent agencies.

Recommendations

CPPR's primary goals for this project were to provide CDSS with descriptive information on state agency data systems, to discuss the possibility of data from these systems being used to address AB 636 indicators, and to provide broad recommendations as to how CDSS might best proceed in their quest to facilitate the assessment of well-being. The following, then, are those broad recommendations. Although ordered here to indicate some degree of importance and priority, this ordering is not meant to signify a requisite chronological sequence. Indeed, many of the action steps embedded in the recommendations can and should be undertaken simultaneously, whereas others might require an iterative approach (i.e., doubling back to certain action steps as progress occurs in other areas). Implementation of the majority of these recommendations will also require significant interdepartmental cooperation, and the pooling of data and programmatic expertise from a number of the agencies that provide critical, ongoing services to CWS children.

Moreover, in regard to prioritization, it became clear during the course of CPPR's investigations that there are a number of indicators for which data are readily available, and a number for which data simply do not exist in any state agency at this time. For this reason, it might prove useful to separate indicators into (a) those that should be pursued immediately, (b) those that will require longer-term efforts, and (c) those that would require a large (perhaps prohibitive) degree of time and human resources to pursue.

1. **ESTABLISH MOUs WITH THE DEPARTMENTS OF HEALTH (DHS), MENTAL HEALTH (DMH), AND EDUCATION (CDE).**
   Along with data possessed by CDSS in the CMS/CWS case management system, data within DHS, DMH, and CDE are the most relevant to AB 636 well-being indicators. In the course of CPPR's investigations, DHS, DMH, and CDE all expressed a keen interest in collaborating with CDSS to locate and track CWS children in their own systems. Representatives from DHS also expressed a strong desire to work with CDSS on issues above and beyond AB 636, noting the high degree of overlap in the adult and child populations served by both departments. In establishing MOUs, decisions will need to be made regarding, for example, where relevant work will be located.

2. **RESOLVE ISSUES RELATED TO DATA INTEGRATION AND CONFIDENTIALITY.**
   Most if not all of the agency representatives involved with this report cited confidentiality as a fundamental concern in terms of data sharing among departments. Analysis must therefore be completed to determine what can and cannot be shared across agencies, and the most feasible and responsible strategies for working within current data confidentiality guidelines. These strategies might include the conducting of surveys, de-identification of individual clients, or the sharing of aggregate information between departments. Further discussion can be found in the body of this report.

3. **CLARIFY AB 636 WELL-BEING INDICATORS.**

The 15 indicators written by the Accountability Workgroup were designed with best practices in mind, rather than the existence of data needed to operationalize them. Although CPPR supports the Workgroup's efforts to be broad and inclusive in their discussions of well-being, advancement from this point would be aided by a thorough review of these indicators. Such a review should be undertaken with an eye toward improving their clarity and specificity, and determining which indicators are the most crucial to pursue at this time.

In terms of clarity and specificity, there were many instances in CPPR's investigation process when it was difficult for agency representatives to determine whether the indicator could be addressed because the dependent variable in question was unclear. Indicator 7A, for example, reads: "Percent of parents able to access and use the support services identified in case plans." This indicator could cover a wide array of services, some of which are overseen by the agencies involved in this report, some of which are not. In other cases, the dependent variable was clear (e.g., students should be performing "at grade-level"), but there is no indication in the indicator's wording as to how the committee would like grade-level to be measured. To proceed, therefore, indicators should be further clarified, given a time frame if necessary (i.e., "within 30 days"), and further elucidated in terms of intent. Once the indicators in need of clarification have been pared down and prioritized, short- and long-term strategies will become more evident.

4. **IMPROVE THE PROCESSES BY WHICH DATA ARE GATHERED, ENTERED, AND ANALYZED IN CDSS'S CHILD WELFARE SYSTEM/CASE MANAGEMENT SYSTEM (CWS/CMS).**
Currently, any new well-being measure developed by CDSS's AB 636 data subcommittee is accompanied by an *All County Information Notice* to provide county child welfare agencies specific instruction for entering information into CWS/CMS. It is

anticipated that this practice will result in more consistent information being entered into the system, therefore making the data more reliable. If improvements continue to be made in the thoroughness and reliability of CWS/CMS data, it is theoretically possible for CDSS to address at least 14 of the 33 outcomes investigated by CPPR—with data from other state agencies, perhaps, serving to augment or validate this CWS/CMS information.

It should also be noted that several of the current well-being indicators are specifically geared toward CWS/CMS processes and would therefore be unavailable from any other state agency. For example, there are three indicators dealing with the maintenance of Health and Education Passports (HEPs). As HEPs are generated by the CWS/CMS system, the ability to determine the percentage of children for whom this was accomplished lies exclusively with CDSS. There are also several indicators related to health and mental health (particularly dental and vision exams, mental heath screenings and referrals, and immunizations) that deal with information that is required to be entered into a foster child's HEP. Although those data may be available through DHS, there is already a system in place for the transfer of all of this information back to case workers. It is CPPR's recommendation, therefore, that the reliability and thoroughness (i.e., the usability) of CWS/CMS data continue to be investigated, followed by an analysis of the causes of any shortcomings that are found (i.e., whether it is timeliness, accuracy, and/or thoroughness that are of issue). With more in-depth information on what is and isn't available in CWS/CMS and why, CDSS would be better positioned to make decisions on the efficiency of (a) undertaking internal improvements, versus (b) pursuing external data.

Finally, it should be noted that—although it seems appropriate to utilize data sets from partner agencies—there is no guarantee that data from those agencies are either valid or reliable. Regularly analyzing the data maintained by all state agencies would improve

both the integrity and reliability of those data, thereby reinforcing confidence in the measurement of the AB 636 indicators.

5. **DECIDE UPON THE DEGREE TO WHICH SAMPLING IS OR IS NOT ACCEPTABLE AS A STRATEGY FOR ADDRESSING THE INDICATORS.** CDSS currently conducts a statistically valid annual survey of birth and foster parents to obtain well-being information specific to assessment for and receipt of educational, health, and mental health services. Consideration should be given, therefore, to the feasibility of adding items regarding perceived *access* to these support services (e.g., as reflected in indicator 7A), as such information is unlikely to be accessible in any administrative database. Similarly, there are several education-related indicators that cannot be matched at the individual level and do not exist at the state level, but may be accessible in some form at the district level. A crucial next step for CDSS, therefore, would be to reach a definitive agreement (either internally or with state or federal officials) on whether or not it would be acceptable under the new outcomes and accountability system to address some of the indicators via a representative sample of specific groups.

6. **DETERMINE THE POSSIBILITY OF CREATING A CENTRALIZED DATA WAREHOUSE.** Centralized integration of administrative data from multiple government agencies is both the most challenging and, ultimately, most promising strategy for tracking the movement of individuals over time and across service categories. States have long investigated the feasibility of integrating existing databases in a central location, either once (for the purposes of one-time research or evaluation) or in an on-going fashion. The latter approach would enable independent evaluators and/or the agencies themselves to ask and answer a range of questions about the individuals served. In terms of CDSS's current attempts to track the well-being of CWS children, data warehousing could either be limited to the specific variables determined to be directly relevant to the tasks of

matching and outcome analysis; or the approach could be more ambitious, feeding entire de-identified datasets into a centralized location on an on-going basis. There are many challenges to either approach. First, agency data systems would need to be analyzed to a deeper degree than was possible in the current project. Second, once multiple agencies agreed to participate in the project and performed these preliminary variable-level analyses, issues of system compatibility, database structure, record formatting, and storage capacity would need to be analyzed, most likely with the help of independent technical consultants who have experience working with large administrative datasets. Confidentiality would also be of paramount importance in any warehousing arrangement, with the data needing to be de-identified and/or the security of the server assured. Finally, issues of reliability, linkage, and coding schemes would present further challenges and would require the ongoing commitment of all involved agencies. Several states have included the investigation of data integration in their Program Improvement Plans (PIPs) and several California counties have already attempted the warehousing of cross-agency data. Analyses of their experiences could prove extremely valuable.

In conclusion, CPPR has determined the following:

1) Data are available within CDSS or other SIT member agencies to adequately address 18 of the 33 outcomes.

    a. MOUs should be established between CDSS and DHS, DMH, and CDE.

    b. A decision should be made to determine where and by whom relevant data integration will be accomplished (e.g., by state staff, by contractors).

    c. Clarify indicators as needed to realize data integration.

2) Data are available within CDSS or other SIT member agencies to partially address 4 of the 33 outcomes.

    a. Improved data from state and/or county sources could be of considerable benefit in addressing these 4 indicators

b. Clarification of indicators could result in the ability to address these 4 outcomes.

3) Data are not available within any of the state agencies investigated by CPPR to address 11 of the 33 outcomes.

a. CDSS should determine the importance of these indicators to prioritize which should be pursued further.

b. If the indicators are deemed of sufficient importance, a strategy should be developed and pursued to gain access to relevant data (e.g., via a survey with appropriate sampling, improved data collection within CWS/CMS).

c. If an indicator is determined not to be of sufficient importance, a decision should be made to abandon it.

d. If it is not feasible to obtain data for an indicator, a decision should be made to clarify or change the indicator, or to eliminate it.

I. BACKGROUND

Improved coordination and collaboration among government agencies that promote the well being of vulnerable children is one of California's top priorities. These efforts recognize that the needs of children are not compartmentalized, but span the breadth of services and supports provided by government agencies.

On October of 2002, HHSA commenced the first of its biweekly meetings with the Child Welfare Outcomes and Accountability Workgroup, comprised of members representing foster parents, foster youth, providers, researchers, social workers, mental health, education, advocates, the Legislature, and Counties. HHSA charged the Workgroup, in consultation with the Chapin Hall Center for Children, with creating a new Child Welfare Outcomes and Accountability System—an unprecedented and historic effort to reform California's child welfare system. The heart of the new system is state and local accountability, pursued in part by an outcomes-based child and family service review of all 58 county child welfare departments. Such a review is designed to be consistent with the requirements of Assembly Bill 636 (AB 636 - Steinberg), which provides a framework for action toward accountability, requiring HHSA convene a workgroup to establish a work plan by which new outcome-based reviews would be conducted in all counties. One of the bill's primary goals was to encourage the state leadership that would be necessary to identify and replicate best practices in meeting the unique and critical needs of California's children.

Although the federal government has provided all states with a list of outcomes to be measured in their periodic child welfare services (CWS) reviews, the Workgroup was interested in developing a comprehensive list of outcomes to measure the performance of each county child welfare department. These indicators—which cover the areas of safety, permanency, and well-being—can be found in the *Outcomes and Process Matrix*, reproduced in Appendix 1.

Paralleling and supporting the work of the Child Welfare Outcomes and Accountability Workgroup, the **State Interagency Team for Children and Youth (SIT)** is leading the effort to better coordinate policies, services, and strategies for children and families in California. Formed in 2003, the SIT is comprised of deputy directors from 10 state agencies and departments. The SIT provides innovative leadership and guidance to facilitate local implementation of system improvements, with areas of focus including:

- Escalating policy and programmatic issues to senior leadership levels so that services can be better coordinated and obstacles removed
- Maximizing funding for services that support children, youth and families
- Removing systemic and regulatory barriers
- Ensuring that policies, accountability systems, and planning are outcome based
- Sharing information and data

State agencies and departments represented on the SIT include the Departments of Social Services (DSS), Health Services (DHS), Education (CDE), Mental Health (DMH), Alcohol and Drug Programs (ADP), Developmental Services (DDS), and Employment Development, as well as the Attorney General's Office, the California Children & Families Commission, the California Workforce Investment Board, and the Administrative Office of the Courts (AOC).

Operating as a subcommittee of the larger SIT, the **Core Indicator Workgroup** was specifically charged with focusing on the child and family well-being indicators developed by the Accountability Workgroup. Although the indicators developed by the Accountability Workgroup cover the areas of safety, permanency, and well-being, a number of those related to safety and permanency can be addressed by existing administrative and case management data maintained byCDSS, particularly CDSS's Child Welfare Services/Case Management System (CWS/CMS). Although CWS/CMS contains some of the data elements needed to measure indicators in the area of well-being, the vast majority of these cannot be thoroughly and reliably addressed through what is, by design, a case management rather than outcome assessment system. It was the belief of the Core Indicator Workgroup that the measurement of well-being would require a far more collaborative, cross agency effort.

The Current Project

The well-being indicators developed by the Accountability Workgroup were designed to cover multiple life domains. As a result, the child, youth, and family services related to the indicators are furnished by a variety of state agencies. It was the belief of all partners involved in the design process that cross agency indicators would not only provide as comprehensive a picture of well-being as possible, it would also encourage shared accountability for improved outcomes. The difficulty inherent in such an effort, however, arises from the fact that individual agencies' data systems were not, for the most part, designed to produce outcome data, or with data transfer and data sharing explicitly in mind. Achieving the state's ultimate goal of addressing these well-being indicators accurately and efficiently will require a long-term effort.

Following the formation of the Core Indicator Workgroup, CDSS was charged with coordinating the analysis of relevant SIT member agencies' key data systems and identifying the potential for using these data systems for AB 636 reporting. In April of 2006, CDSS made a formal request to the University of California, Davis's *Center for Public Policy Research* (CPPR) for technical assistance on this project. CPPR's was officially contracted to perform the following functions:

- Assess possibilities and make recommendations for integration and shared data management of data from all departments to better realize AB 636 outcome measures.
- Investigate and propose opportunities for data integration and utilization.
- Identify information available on AB 636 issues

Subsequent to these investigations, CPPR's task was to provide CDSS and the Core Indicators Workgroup with several interim reports, formal interim and final presentations, and a final report summarizing all findings and recommendations. The current report serves the latter function.

Overview of the Current Report

Between May and August of 2006, CPPR met with representatives from the following agencies:

- California Department of Health (DMH)

- California Department of Mental Health (DHS)

- California Department of Education (CDE)

- California Department of Developmental Services (DDS)

- California Department of Alcohol and Drug Programs (ADP), and

- the Administrative Office of the Courts (AOC).

The primary purpose of these meetings was for CPPR to gather information on each agency's data systems, particularly databases containing information germane to the AB 636 child well-being indicators. Prior to meeting with each agency, CPPR provided agency representatives (primarily staff with a high degree of familiarity with the agencies' data systems) with a list of the indicators related to the services they provide or life domains most likely to be reflected in their data systems. Agency representatives then worked with CPPR staff to identify the most promising databases housed within the agency, and the particular data elements (i.e., variables) most likely to be applicable to the indicators in question. In addition, CPPR sought information on the reliability and validity of the data, as well as information on the unique indicators and individual-level demographic variables maintained within the datasets.

As the Core Indicator Workgroup considers the current project to be an initial rather than in-depth inquiry, the findings detailed in this report are limited to broad, descriptive information on the agencies and databases investigated by CPPR. This includes: (a) names and descriptions of the datasets deemed relevant to the well-being indicators; (b) discussions of how and how well the data within the databases could be used to address various well-being indicators; (c) any available information on the reliability of the data itself; and (d) information on the demographic variables in the datasets that could be useful in data integration or probabilistic matching with data from other agencies.

The indicators in the *Outcomes and Process Matrix* are labeled 5A through 8E, and represent a total of 15 measures, many of which can be further broken down into a total of 33 component outcomes. For the purposes of the current report, therefore, the indicators have been broken down and categorized in the following manner:

Health and Mental Health

5A	% of children in care more than 30 days with a Health Passport
5B	% of children in care with CHDP that comply with periodicity table
	% of children in care with dental exams that comply with periodicity table
	% of children in care with psychotropic medication consultations
	% of children in care with immunizations that comply with periodicity table
5C	% of CWS children with mental health referrals who receive mental health services, stratified by in-home vs. out-of-home care
5D	Family maintenance children receive Health Passports and screenings
5E	% of children in care who receive an initial mental health screening within 30 days of initial placements

Education

6A	% of children in care more than 30 days with a Health and Education Passport
	% of children in care more than 180 days with a Health and Education Passport
6B	% with school change during the year
	# of school changes during the year
	% of children with Individualized Education Plan
	% of children performing below grade level
6C	% of school aged children enrolled within 1, 2, 3, and 4 weeks or more of initial out-of-home placement
	% enrolled within 1, 2, 3, and 4 weeks of placement change
6D	% with adequate yearly attendance
	# of school days missed
	% in non-public schools

% of children enrolled in the same school

Of children with an IEP, % who received services

6E   % of children in care at grade level on standardized state tests, stratified by special and regular education (by entry cohort, age, and placement type)

Support Services

7A   % of parents able to access and use support services identified in case plans, by case closure

Emancipation and Legal Issues

8A   Of youth emancipating from foster care:

% with high school diploma or GED

% enrolled in college or higher education program

% with receipt of Independent Living Program (ILP) services

% who complete vocational training program

% who are employed or have other means of support

8B   Of youth exiting from foster care:

% with a legal emancipation hearing or termination of jurisdiction hearing

% with the documents required by AB 686

8C   Of youth in foster care who completed a Living Skills Assessment:

% who are identified as needing self-sufficiency skills training

8D   Of youth in foster care:

% who are on probation or incarcerated

% who are transferred into the juvenile justice system

The current report will be structured around these 33 outcomes, with separate sections for each of the major life domains represented in the four indicator categories above: Health and Mental Health, Education, Social Support, and Emancipation and Legal Involvement. Each section will provide an overview of the indicators, a list of the department(s) CPPR consulted, and indicator-by-indicator analyses detailing all relevant findings. This includes descriptions of the databases that might contribute to the indicators' measurement; all available information on the

data (and specific variables) that may be of greatest interest to CDSS; and a discussion of any issues related to the wording of the indicator itself (and/or possible changes to the indicator) that may affect CDSS's ability to measure it. In some cases, for example, it was difficult to determine whether data were available to address an indicator due to the indicator's lack of clarity or specificity. Each section will conclude with a summary of findings and brief list of recommendations.

Finally, as many of the data integration, data sharing, and confidentiality issues that arose during CPPR's investigations are relevant to multiple departments, these issues are addressed in Section VII, rather than throughout the report.

II. HEALTH AND MENTAL HEALTH INDICATORS

Overview of the Indicators

Well-being indicators 5A-5F involve the timely and appropriate receipt of health and mental health services by CWS children. "Services" include provider contacts related to physical, dental, mental health, and vision screenings; receipt of health and mental health referrals; and receipt of the recommended follow-up or treatment services indicated by those screenings and referrals. In this section of the report, indicators will be grouped for analysis as follows:

Health Passports

5A % of children in care more than 30 days with a Health Passport

5D Family maintenance children receive Health Passports and screenings

Health Screenings and Exams

5B % of children in care with CHDP that comply with periodicity table

   % of children in care with dental exams that comply with periodicity table

   % of children in care with psychotropic medications consultations

   % of children in care with immunizations that comply with periodicity table

Mental Health Screenings, Referrals, and Services

5C % of CWS children with mental health referrals who receive mental health services, stratified by in-home vs. out-of-home care

5E % of children in care who receive an initial mental health screening within 30 days of initial placements

Agencies and Data Systems

The agencies consulted in regard to these indicators were DMH and DHS, both of which maintain multiple administrative datasets. The majority of the datasets maintained by both departments are related to, or are subsets of, the population covered by DHS's Medi-Cal

Eligibility Data System (MEDS). Therefore, after reviewing written and oral information related to DMH and DHS databases, it was determined that the following two databases contain information that could be used to address the specific health and mental health indicators listed above.

Medi-Cal Eligibility Data System (MEDS)

MEDS is a statewide dataset administered by DHS and developed from the federal government's design for a model Medicaid Management Information System (MMIS). MEDS maintains a record for every individual who has been reported as Medi-Cal eligible since MEDS implementation began in 1981. Each county regularly sends to MEDS information from its individual data systems about TANF recipients, primarily so MEDS can produce Medi-Cal cards. The information maintained on MEDS comes from counties, federal agencies, DHS, and other sources (e.g., private health care plans). MEDS is generally used for managing the issuance of Medi-Cal cards, tracking enrollment in other health insurance programs, and processing claims.

The data available on MEDS include Medi-Cal program participation, county of residence, Medi-Cal Share of Cost, provider type, and health insurance information for all Medi-Cal recipients. For TANF recipients, MEDS records indicate the TANF program code for each month and contain other demographic information. The eligibility file on MEDS is an individual-based system, and the primary identifier used to locate individuals in the system is the individual Medicaid recipient's Social Security number. Also available are the name, date of birth, address, race, and gender of each individual, and the individual's TANF case number or SSI case number, if they are using one of those programs. A 10-digit space is available for the recipient's public assistance case number. Every TANF recipient has a seven-digit TANF serial number assigned by the county. Two digits contain the county code and one digit indicates if the individual is in one of multiple assistance units within the case. All individuals in a TANF case can be pulled together through their common case number, and this number, combined with the county code, is unique throughout the state.

The Client and Service Information System (CSI)

The CSI is a statistical information system that includes data on all persons served in county mental heath programs in California. CSI data are reported monthly by county programs via DMH's *Information Technology Webserver* (ITWS). Summary statewide and county reports are also sent back to counties via the ITWS. There are three types of records reported to CSI: client records, which include client characteristics, such as date of birth, race/ethnicity, and language; service records, which include information about the service encounter, such as date of service, type of service, and diagnosis; and periodic records, which include types of client data that are collected less frequently, such as living situation and employment status. The primary identifier used to locate individuals in the system is the County Case Number (CCN). As of July 2006, the Client Identification Number (CIN) has also been added to the system. The CIN is a 9-digit alphanumeric character supplied from data created in the Statewide Client Index (SCI) system. CINs are shared across all programs participating in the use of SCI (including Medi-Cal, Healthy Families, and California Children's Services) and are crossed-referenced to MEDS IDs in the MEDS system. Also available are a range of demographic variables, such as name, gender, date of birth, mother's name, and address

Indicator Analyses

Health Passports

5A   % of children in care more than 30 days with a Health Passport

5D   Family maintenance children receive Health Passports and screenings

Indicators 5A and 5D involve the timely receipt of Health and Education Passports (HEP). HEPs are designed to maintain a detailed summary of all CWS children's health and education information, consistent with the Welfare and Institutions Code Section 16010. Currently, this document is maintained by CDSS and linked to the data entered by case workers into an individual child's CWS/CMS case plan. The document is designed to automatically populate and undergo automatic revisions each time a child's electronic file is updated. In addition, case

workers are mandated to provide children with a hard copy of their HEP, which should then accompany the child to all medical, dental, and psychological appointments, as well as to all relevant meetings with education providers.

Due to the nature of HEPs (i.e., their link to the existing CWS/CMS system), CPPR felt the information needed to address these indicators can (and can exclusively) be extracted from the CWS/CMS system and/or hard copies of the child's case file.

Health Screenings and Exams

5B   % of children in care with CHDP that comply with periodicity table

% of children in care with dental exams that comply with periodicity table

% of children in care with psychotropic medication consultations

% of children in care with immunizations that comply with periodicity table

The four measures constituting well-being indicator 5B involve the receipt of various health services, including the initial *Child Heath and Disability Prevention* (CHDP) screenings CWS children are mandated to receive within 30 days of out-of-home-placement. CHDP preventive health assessments are provided through a range of health care providers, including private physicians, local health departments, schools, nurse practitioners, dentists, health educators, nutritionists, laboratories, community clinics, nonprofit health agencies, and social and community service agencies. The following services are provided by the CHDP program:

- Health and developmental history
- Complete physical examination
- Oral health assessment
- Nutritional assessment
- Behavioral assessment
- Immunizations as appropriate for age
- Vision screening
- Hearing screening

- Screening tests for anemia, blood lead, tuberculosis, urine abnormalities, sexually transmitted diseases, and other problems as needed
- Health education and anticipatory guidance

CHDP data are maintained by the CHDP program, which is administratively housed within DHS. In addition, all CHDP providers are required to forward CHDP data back to the child's caseworker via a hard copy of the CHDP PM 160 form. The data from these forms, which are typically completed by public health nurses or the providers themselves, are also entered into a database maintained by the CHDP program. Those data then move through a fiscal intermediary and into the larger MEDS database maintained by DHS.

Given that indicator 5B reflects both CHDP screenings and the specific services that constitute them (dental exams, vision screenings, and immunizations), the data related to all aspects of this indicator are most likely to reside in DHS data systems. During and subsequent to CPPR's meeting with DHS, agency representatives did not provide specific information on the reliability of these data, the timeliness of its eventual transfer into the MEDS database, nor information on the specific variables related to screening and exam types. DHS representatives did confirm, however, that all available data related to the CHDP program are accessible through their department. In addition, DHS informed CPPR that—although there are additional, regional immunizations registries—the data within these registries is voluntarily reported and incomplete. DHS representatives noted, however, that all immunization information listed on the CHDP PM 160 forms is returned to a child's caseworker.

It was also anticipated by CPPR that CalWORKS data could also be useful in addressing the immunization aspect of this indicator, as the children of adult recipients are required to be up-to-date on immunizations. CalWORKS representatives stated, however, that individual-level data on immunizations is not reported to them, nor likely to be maintained at the county level in a reliable, uniform fashion. Such data may exist at the local level, yet is, in many cases, self-reported and not in electronic form.

Mental Health Screenings, Referrals, and Services

5E   % of children in care who receive an initial mental health screening within 30 days of initial placements

5C   % of CWS children with mental health referrals who receive mental health services, stratified by in-home vs. out-of-home care

Indicator 5E and 5C deal with CWS children's receipt of mental health screenings, referrals, and services. In reviewing these outcome areas, DMH representatives determined that data related to mental health screenings and mental health referrals are not maintained by their department, but may be available from county mental health organizations. CPPR's conclusion, therefore, was that neither indicator can be addressed using DMH data.

One issue that arose, however, was the question of what constitutes a "screening" or a "referral" for the purposes of these indicators. For example, both DMH and CPPR were unclear as to whether CDSS was specifically (or exclusively) interested in screenings and referrals that take place through (or result from) a child's CHDP exam. If so, the data needed to address these indicators may be culled from the MEDS database. If screenings and referrals that take place outside the CHDP programs are of interest, the data needed to address these indicators thoroughly would be extremely difficult to locate. Although the majority of CWS foster children are likely to bill for such services through Medi-Cal (due to their Title IVE eligibility), private pay visits may occur. In addition, many services that could be considered mental health screenings and referrals may occur during more comprehensive visits with a pediatrician or family practice doctor, and would therefore not appear in the MEDS database as a mental health provider contact.

Some data related to mental health services (i.e., treatment as opposed to screenings and referrals) are available through DMH, primarily in the CSI database. DMH representatives felt that mental health service information is also available in the MEDS database, but that CSI is likely to contain more complete records of mental health provider contacts, in that MEDS data

only reflects paid claims. CSI does not have that restriction, containing information on all services regardless of payor.

DMH also noted that the term "services" could be applied to a wide range of provider contacts —everything from routine medication consultations to involuntary detention in drug rehabilitation facilities. To properly assess this indicator, therefore, CDSS (perhaps with the assistance of DMH representatives) would need to determine which particular services would be appropriate to capture based on the *intent of the indicator* as it is currently written. Stated another way, given that the indicator specifically relates mental health *services* to the mental health *referrals* that prompted them, one challenge when assessing this indicator would be the proper identification of provider contacts related to a CWS child's documented needs, as opposed to services that resulted from unrelated emergencies, newly emerging mental health conditions, substance abuse, etc. Once these issues are clarified, DMH representatives would be able to identify which particular variables or service codes within CSI could be utilized in the assessment of this indicator.

Summary

Five indicators were addressed in this section, two of which (5A and 5D) are related to HEPs and therefore available to CDSS through its own CWS/CMS system.

The various measures constituting indicator 5B are accessible through DHS data systems, specifically the CHDP or MEDS database. These data would only reflect paid claims for services rendered through the CHDP program and would not reflect any health exams that take place outside this program or paid for through any means other than Medi-Cal. Information on mental health screenings (which take place as part of a child's comprehensive CHPD exam) would also be available through DHS.

The mental health data necessary to address indicator 5E may be partially accessible through DMH's CSI database. However, it was both DMH and CPPR's belief that without the mental

health referral information the indicator is conditioned upon, service information alone would be insufficient. If referral information can be located through DHS, the indicator still suffers from complications related to the appropriate matching of services to referrals. A data algorithm would need to be written that was capable of coding referral types, then locating service provider contacts temporally and thematically likely to have resulted from the initial referral.

In terms of the Core Indicator Workgroup's interest in cross agency data sharing, it should be noted that DHS expressed a great deal of interest in working with CDSS, not only in relation to CWS children, but to the broader population of Californians served by both departments. Short of such future collaborations between the two departments, it was DHS's express recommendation that CDSS go through the DHS formal data request process in order to address well-being indicators 5B, 5C, and 5E. Such requests go through DHS's Center for Health Statistics (CHS), which not only facilitates the collection, validation, statistical analysis, and dissemination of health data in support of DHS's mission, but is also responsible for providing technical assistance relating to vital statistics data to users external to DHS (local government, academia, researchers, the general public, etc.) The CHS is comprised of the Office of Vital Records (OVR), the Office of Health Information and Research (OHIR), the Administration Support Section, and the Information Technology Services Section (ITSS). Specific data requests by CDSS to the CHS could occur in one of two ways: CHS staff could identify foster care children within the MEDS database using foster care eligibility aid codes; or CDSS could provide CHS with a list of the social security numbers of their population of interest, and CHS could then work to locate those individuals within their system. In either scenario, CHS data experts could work to extract all paid claims related to health and mental health services provided through CHDP or paid for through Medi-Cal. If given specific research questions (i.e., operationalized versions of the indicators), CHS could provide CDSS with answers to their questions rather than providing the actual data. It should also be noted that future plans for requesting health data will also need to include the planned reorganization of DHS into two departments, effective July 1, 2007. The California Department of Public Health (CDPH) will

include the Center for Health Statistics. The Department of Health Care Services (DHCS) will include Medi-Cal and Children's Medical Services (CMS).

Recommendations

For indicators 5A through 5E, CPPR's recommendations to DDS are as follows:

1. Utilize DHS's official data request process. CHS data experts can locate CWS children in the MEDS database and extract all available information on health, dental, and vision services. This can be accomplished by requesting DHS to locate foster children using MEDS aid codes or by providing DHS with a list of the social security numbers of the individuals in which they are interested.

2. Consider revisiting indicator 5C (% of CWS children with mental health referrals who receive mental health services), or working closely with both DMH and DHS data experts to devise a strategy for addressing the conditional nature of the indicator.

3. Consider strengthening the process related to data transfer from CHDP providers, to the CHDP PM 160 forms, and into the CWS/CMS system. Given that HEPs are mandated to be complete and updated for all foster care children, and given that the fields for all health and mental health screenings, exams, and services exist within CWS/CMS, CDSS should have electronic access to all of the indicators discussed in this section.

4. Internally assess the total proportion of health and mental health services likely to be captured through paid Medi-Cal claims alone.

III. EDUCATION INDICATORS

Overview of the Indicators

Well-being indicators 6A-6E involve school enrollment, attendance, stability, performance, and individualized education plans for CWS children grades K-12. In addition, select aspects of indicator 8A reflect participation in higher education programs and will also be included in this section. Indicators will be grouped for analysis as follows:

Health and Education Passports

6A   % of children in care more than 30 days with a Health and Education Passport

        % of children in care more than 180 days with a Health and Education Passport

School Enrollment

6C   % of school aged children enrolled within 1, 2, 3, and 4 weeks or more of initial out-of-home placement

        % enrolled within 1, 2, 3, and 4 weeks of placement change

        % in non-public schools

School Stability

6B   % with school change during the year

        # schools changes during the year

6D   % of children enrolled in the same school (as prior to placement)

Individualized Education Plans

6B   % of children Individualized Education Plan

6D   Of children with an IEP, % who received services

School Performance

6B   % of children performing below grade level

6E   % of children in care at grade level on standardized state tests, stratified by special and regular education (by entry cohort, age, and placement type)

School Attendance

6D   % with adequate yearly attendance

# of school days missed

Higher Education

8A   % with a high school diploma or GED

% enrolled in college or higher education program

% who complete vocational training program

Agencies and Data Systems

The agency consulted in regard to these indicators was CDE, 107 databases and 128 data collections containing data at the individual, school, and district level. Of those, only four collect any data related to foster (or neglected) children and none of these collect data at the individual level. Databases relevant to each indicator grouping will be discussed throughout (rather than prior to) the indicator analyses.

Indicator Analyses

Health and Education Passports

6A   % of children in care more than 30 days with a Health and Education Passport

% of children in care more than 180 days with a Health and Education Passport

As discussed in the previous section, information related to HEPs is available to CDSS through the CWS/CMS system and will not be addressed here.

School Enrollment

6C   % of school aged children enrolled within 1, 2, 3, and 4 weeks or more of initial out-of-home placement

% enrolled within 1, 2, 3, and 4 weeks of placement change

% in non-public schools

Data most relevant to school enrollment are maintained by the *California School Information Services (CSIS) Program*, a program stemming from a 1997 legislative initiative requiring the

development of an electronic statewide school information system in California. One of the priorities of the CSIS program is the facilitation of student record exchange between participating local educational agencies (LEAs), as well as the reporting of student information to CDE. However, in terms of student record exchange, CSIS's priority has been exchanges between LEAs and postsecondary education institutions, rather than between LEAs themselves.

To enable California to meet the federal requirements, Senate Bill 1453 (SB 1453) was enacted in September 2002 to require: (1) the assignment of individual, yet non-personally identifiable student identifiers to all K-12 students enrolled in California public schools; and (2) the establishment of the *California Longitudinal Pupil Achievement System (CALPADS)* that includes statewide assessment data, enrollment data, and other demographic elements required to meet federal NCLB reporting requirements. The assignment of student identifiers is the responsibility of the California School Information Services (CSIS) program; the SB 1453 grant program, and the establishment of the longitudinal data system is the responsibility of the CDE.

The challenge with CALPADS, however, is that schools report student enrollment data to CDE once annually (in the fall of each academic year) and there are no statutory or regulatory requirements that LEAs update the *Student Locator System* every time a student enrolls in a new school. For that reason, the data would be of limited usefulness in addressing the enrollment indicators. The first two parts of indicator 6C are designed to measure the timeliness of student enrollment (within 1, 2, 3, and 4 weeks of placement or placement change). Enrollment data are simply not available at fine enough intervals at the state level to address such questions. CDE representatives also reported that, although some LEAS collect enrollment data more frequently, none are likely to do so in the nearly streaming fashion necessitated by the indicators.

Beginning this academic year (2006-2007), CDE will collect enrollment and assessment data for public students that are being served by non-public schools under a contractual agreement between the LEA and the non-public school (i.e., a certified non-public school). However, a

generic school code is being used to identify the non-public schools, so the data are limited in that CDE can only state how many students in an LEA were served by a non-public school. Next year, CDE plans to collect a unique school code to allow them to identify which certified non-public schools are serving public students.

School Stability

6B   % with school change during the year

        # of schools change during the year

6D   % of children enrolled in the same school (as prior to placement)

The annual nature of CDE enrollment data also creates challenges in relation to indicator 6B. With only fall enrollment data available, school changes *during* the year cannot be assessed. There is a possibility, however, that a single school change within an academic year could be tracked using a combination of fall enrollment data (from the *Student Locator Database*) and information from CDE's standardized testing databases (some of which include data elements to identify the school in which the test was taken). However, the data would only allow for a determination of whether or not a student remained in the same school from fall to spring. The number of changes could not be determined, only the percent who underwent at least one change.

In terms of indicator 6D, CDE representatives felt that an assessment of whether a child is enrolled in the same school before and after initial out-of-home placement could be addressed on the condition that CDSS could accurately identify the school in which the child was enrolled immediately prior to placement. CWS/CMS representatives informed CPPR, however, that although the system has the capacity to capture school enrollment at the time of placement, such information is not always captured in a reliable fashion.

Another difficulty created by this approach is that the intent of the indicator is to capture school changes that occur as the result of placement or placement change, but it may be difficult to

parse out students whose school changes were the result of their CWS involvement from those making natural progression from one school type (grade, elementary, high school) to the next.

Individualized Education Plans

6B   % of children with Individualized Education Plan

6D   Of children with an IEP, % who received services

Identification of students with IEPs is possible through the *California Special Education Management Information System (CASEMIS)*. This database contains student-level data on demographics, types of services and providers, and program exit. Data are limited to those individuals between the ages of zero and 22 years receiving special education or related services. LEAs submit these data through their state education local plan area (SELPA) office. The determination of which particular CASEMIS variables are of greatest interest is contingent upon CDSS identifying the specific IEP-related services they are interested in tracking.

School Performance

6B   % of children performing below grade level

6E   % of children in care at grade level on standardized state tests, stratified by special and
         regular education (by entry cohort, age, and placement type)

In the spring of each academic year, CDE requires its public schools to give a set of tests to all students in grades 2–11. These tests are part of the *Standardized Testing and Reporting* (STAR) program, which maintains extensive student-level data and testing results. Although some of the test questions measure students' mastery of basic skills, their main purpose is to see how well schools are teaching and students are learning up to content standards in four core subjects: English-language arts, mathematics, science, and history/social science. STAR encompasses three different kinds of tests:

- CSTs (California Standards Tests), which are based on the state's standards—what students are supposed to know and be able to do at each grade level;

- CAT/6 (California Achievement Test, Sixth Edition), a test of basic skills;

- SABE/2 (Spanish Assessment of Basic Education, Second Edition), an additional test that native Spanish speakers take during their first year in California public schools.

Student-level results on these standardized tests are maintained in separate CDE databases, the majority of which include a data element for SSID. The question of which particular data elements are of interest is contingent upon CDSS determining (perhaps with the assistance of CDE representatives) which tests, composites, or state standards-aligned results are most suited to the intent of the indicator.

It should also be noted that addressing both of these indicators with STAR data would, in essence, make them compliments of one another. Calculation of both would not be needed if the Accountability Workgroup chooses to define the phrase "at grade level" using the same standardized tests, scores, and/or subscores. CDSS should determine whether this is the true intent of these indicators (i.e., to be numerically complimentary), or whether it would be preferable to define "at grade level" via classroom grades for one and standardized tests for another (although classroom grades are not available through CDE).

School Attendance

6D   % with adequate yearly attendance

        # of school days missed

School attendance data are not available from CDE at the student level. CDE representatives also noted that LEAs do not have uniform definitions of adequate daily attendance (ADA) nor of truancy. However, Education code section 48260 provides a state definition for truancy and CDE collects count of truants (by this definition) at the school level, not the student level.

It was anticipated by CPPR that CalWORKS data could also be useful in addressing this indicator, as the children of adult recipients are required to maintain adequate school attendance. However, as was the case with immunization information, individual-level data on

school attendance is not reported to the State, nor likely to be maintained at the county level in a reliable, uniform fashion. Such data may exist at the local level, yet is, in many cases, self-reported and not in electronic form.

Higher Education

8A   % with a high school diploma or GED

% enrolled in college or higher education program

% who complete vocational training program

CDE does not collect data from institutions of higher education (e.g., colleges, universities, or vocational schools). The California State University system may begin reporting some data to CDE in the future, but the University of California system has no plans to participate at this time.

Data on high school completion is available through CDE's *California High School Exit Exam (CAHSEE) Annual Detail Data Collection*. The associated database contains student-level high school exit exam information (including test scores), as well as information on the student, school, district, and county in which the test was taken. In addition, the CALPADS system (through the fall SSID maintenance process) includes a code indicating the Student Exit Category. This information could also be used to determine the count of students who dropped out or graduate.

Data on GED receipt are available through CDE's *General Educational Development (GED) Data Collection*. The associated database consists of records of individuals who have completed the test of GED in the state of California, as well as the date and location of testing, test scores, and student-identifying information. This database does not, however, include a data element for SSID.

Summary

In terms of CDE data, the indicators covered in this section fall into one of three categories: those that cannot be addressed with CDE data at this time (school attendance, timeliness of enrollment, nonpublic school enrollment, and higher education); those for which the necessary, individual-level data are readily available (school performance and GED receipt); and those that can be addressed partially or through the creative use of database combinations and advanced algorithms. Matching issues are also of concern, given that CDE does not maintain social security numbers in their databases. Matching and confidentiality issues will be further addressed in Section VII.

Recommendations:

For indicators related to education, CPPR's recommendations to CDSS are as follows:

1. Assess the strength and timeliness of enrollment data entered into CWS/CMS. Given that placement date and school enrollment date are standard entries on a child's HEP, CWS/CMS is likely to be a superior source of information than CDE's *Student Locator Database* for determining the precise timing of enrollments.

2. Determine which IEP-related services are of interest for indicator 6D (Of children with an IEP, % who receive services). CDE representatives can then provide information on whether those services are reliably tracked through their CASEMIS database.

3. Investigate alternative means for tracking higher education outcomes. Given that CWS youth are highly likely to be out of the system (i.e., aged 18 or older) by the time they seek tertiary education, this information is not available through any state agency at this time. One option would be to take a sampling approaching, contacting young adults several years after they have left the CWS system.

4. Secure necessary statutory authority to implement changes in the ways schools and LEAs identify foster children. If foster children could be easily identified by the educational institutions themselves, arrangements could be made for CDE to work with those institutions to periodically collect and assess information on the few (but crucial) education outcomes of interest to both CDE and CDSS, particularly school attendance and stability. However, the CDE would need legislative authority to collect these data from LEAs.

IV. SUPPORT SERVICES INDICATORS

Overview of the Indicator

Well-being indicator 7A involves parents' access and use of the social support services identified in their case plans. There is no indication from the Accountability Workgroup at this time as to whether it is biological parents or foster parents that are of interest. All of the issues discussed in this section, however, are applicable to either. The indicator reads as follows:

> *Support Services*
>
> 7A   % of parents able to access and use support services identified in case plans, by case closure

Agencies and Data Systems

Given the broad nature of this indicator, CPPR representatives addressed it with a number of agencies: DDS, ADP, and various programs within CDSS itself.

Indicator Analysis

As there is only one indicator being addressed in this section, the focus of analysis will be on the databases maintained by the departments. Beginning with DDS, the following is a list of the purpose and content of the primary databases they maintain.

Client Master File (CMF)

The Client Master File (CMF) contains demographic, case status, and service coordinator information on all persons who have applied for services provided by DDS, including those actively being served. The CMF is also used to match eligible clients with services provided using the Purchase of Service data system (see below). CMF data are initially collected at the 21 DDS Regional Centers and are updated annually or more frequently as needed. The case files of all persons in the CMF database who are eligible to receive DDS services are classified by one of three active status codes. Several data elements within the CMF data system were determined

36

as potentially useful in identifying CWS children in the DDS data system: Residence Type, Legal Status, and Case Management Code. The CMF may also contain data on medications; however, the nature and reliability of these data must be further determined.

Client Development Evaluation Report (CDER)

The Client Development Evaluation Report (CDER) contains disability diagnosis and functioning evaluation information for all active clients over the age of three in the DDS system with a diagnosed developmental disability. The CDER is divided into two major sections, the Diagnostic Element and the Evaluation Element. The Diagnostic Element contains information pertaining to the individual's developmental disability(ies), mental disorders, risk factors, major medical conditions, hearing and vision impairments, behavior modifying drugs, special health care requirements, and other special conditions. The Evaluation Element includes information relating to motor, independent living, social, emotional, cognitive, and communication skills. CDER data are collected by the regional centers or by SDCs (for individuals residing at an SDC). A CDER is completed or updated at the time a client's Individual Program Plan (IPP) is developed. DDS representatives also noted that the CDER instrument would eventually include more well-being information on eligible clients, and includes some self-report data relevant to children on probation. The nature of these data must be further explored.

Early Start Report System (ESR)

The Early Start Report System (ESR) contains demographic, diagnostic, developmental, behavioral assessment, and service information for clients in the DDS system younger than 36 months. The ESR is similar to the CDER instrument but contains data items that are more appropriate for infants and toddlers. The ESR system is updated annually or more frequently as needed. CPPR determined that ESR data elements that are related to Medical Assessments and Consultations Services may be used to address indicator 7A.

Purchase of Service System (POS)

The Purchase of Service (POS) System includes authorization information on all clients and contract services claims (e.g., service code, vendor, claim amount) as specified in clients' Individual Program Plan (IPP) or their Individualized Family Service Plan (IFSP). Contained within the POS database are client and service claim information for 149 service types. Service types identified as potentially relevant to indicator 7A can be grouped into the following broad categories:

- Out-of-Home Care—supervision and training for individuals in community care facilities;

- Day Programs—community-based training programs (e.g., behavior management, self-help/self-care skills, community integration, and infant development programs);

- Non-Medical Services—professional services including tutors, special education teachers, recreational therapists, counselors, infant development specialists, and speech pathologists;

- Non-Medical Service Programs—program services including parenting support services, client/parent support behavior intervention training, socialization training program;

- Transportation—transportation provided by transportation companies, residential facilities, day programs, public transportation, family members, friends, or ambulances;

- Prevention Services—services including infant development specialist, nurse's aide or assistant, and public school early intervention program.

One challenge with the POS system, however, is that DDS Regional Centers can submit purchase of service claims to DDS several years after the services have been delivered. As a result, the POS database is subject to change as additional vendor billings are received by DDS for services delivered during previous years. Accordingly, the POS database may not reflect a complete record of services delivered to a particular client, but rather a record of service claims received by DDS for that client. That DDS is a payor of last resort poses an additional challenge.

DDS must use all other available resources, including those provided by other public or private agencies, before using DDS funds. Many of the services offered by DDS (e.g., transportation) to the eligible population are available through alternative organizations (e.g., public schools). As a result, the data maintained by DDS on services provided are not a complete record of the services received by the department's service population. Additional agencies will need to be consulted to identify services received through sources other than DDS.

In addition to these DDS databases, the sole database maintained by ADP may also be applicable to indicator 7A.

The California Outcomes Measurement System (CalOMS)
The California Outcomes Measurement System (CalOMS) is a statewide client-based data collection process and associated database. The CalOMS system was launched in January of 2006, replacing ADP's previous database, the California Alcohol and Drug Data System (CADDS). CalOMS is designed to allow ADP to effectively manage and improve the provision of alcohol and other drug services at the state, county, and provider levels. CalOMS treatment data collection is required from all providers licensed for narcotic replacement therapy and all providers receiving ADP funding for clients receiving the following services:

Non-residential/Outpatient Services:

- Outpatient drug free
- Day care rehabilitative
- Detoxification (non-medical)
- Narcotic treatment—maintenance
- Narcotic treatment--detoxification

Residential Services:

- Detoxification (hospital)
- Detoxification (non-hospital)
- Treatment/recovery (30 days or less)
- Treatment/recovery (30 days or more).

Providers are required to collect client data at admission, as well as at discharge or administrative discharge from the same treatment program. CalOMS data are also collected annually as an update for clients formerly in treatment for a period greater than 12 months. Any provider who receives public funding for treatment services and all Narcotic Treatment Program (NTP) providers must report CalOMS data for all clients receiving treatment, whether those individual client services are funded by public funds or not. An exemption exists for providers who receive funds under the Substance Abuse Crime Prevention Act (SACPA) only. A treatment provider who falls into this category must collect and report CalOMS data only for the clients who are funded through SACPA. They are not required to report CalOMS data for their other clients. Any treatment service provider who does not receive public funding does not report data to ADP. CalOMS data are sent to ADP monthly in batch files from counties and, in some cases, from direct providers. Files are then uploaded into the CalOMS system. CalOMS contains 13 variables related to personal identification, including standard demographic variables (first and last name, gender, date of birth, race/ethnicity), as well as social security number.

It was also anticipated by CPPR that data held by CalWORKs (California's TANF programs) could prove relevant to this indicator. CalWORKs representatives reported, however, that information on any of the services they track (primarily services related to job access and barriers to employment) is generally located in county agencies and contains data on adults participating in public welfare programs. Individual data of children are not regularly recorded though some information may be found as notations in files. County CalWORKs data are contained in local computers, and each county is a member of one of four consortia of counties in the state that share computer systems. At present, the systems used by these four consortia do not interface with one another. In addition, CDSS makes regular reports to federal agencies regarding CalWORKs, but this involves aggregate data reports drawn from samples of county data. Finally, although there is a General Assistance (GA) Component for adults without children, these data are held at the local level and are not uniformly accessible in electronic form.

Summary

It is challenging at this point to determine the feasibility of addressing indicator 7A, in that the category of "support services" is extensive. CPPR has determined that information on alcohol and drug treatment is available, as is information on the developmental services offered through DDS. This information would represent a small portion of the services that can be noted in the case plans of CWS families. Some of the other services are captured in the CalWORKs data systems, but the data would need to be extracted from the various systems used by the four consortiums and then integrated.

Recommendations

1. Re-visit indicator 7A (% of parents able to access and use support services), specifying which services are of greatest interest. At this point it is unclear whether data from the three programmatic areas discussed in this section (alcohol and drug treatment, developmental services, and job preparedness) would represent an adequate proportion of the services CDSS is hoping to track with this outcome.

2. Alternatively, explore the acceptability of approaching the indicator with a survey. Given its current intent (i.e., to capture the ability to *access* services), administrative data would not be adequate in addressing it, regardless of the breadth of service *contacts* that can be captured.

V. EMANCIPATION AND LEGAL INVOLVEMENT INDICATORS

Overview of the Indicator

Well-being indicators 8A-8D involve various emancipation, self-sufficiency, and legal issues. The majority of the indicators are intended to capture well-being at the time of, or subsequent to, emancipation. The exception is 8D, which aims to assess foster children's involvement in the legal system while still in the CWS system. Indicators will be grouped for analysis as follows:

Self-Sufficiency

8A   Of youth emancipating from foster care:

% with receipt of Independent Living Program (ILP) services

% who are employed or have other means of support

8C   Of youth in foster care who completed a Living Skills Assessment:

% who are identified as needing self-sufficiency skills training

Emancipation Issues

8B   Of youth exiting from foster care:

% with a legal emancipation hearing or termination of jurisdiction hearing

% with the documents required by AB 686

Legal Issues

8D   Of youth in foster care:

% who are on probation or incarcerated

% who are transferred into the juvenile justice system

Agencies and Data Systems

In addition to receiving input from CDE on indicator 8A, CPPR sought information on emancipation, legal, and self-sufficiency issues from AOC, the Department of Justice (DOJ), and CDSS experts on CWS/CMS.

Indicator Analyses

Self-Sufficiency

8A   Of youth emancipating from foster care:

        % with receipt of Independent Living Program (ILP) services

        % who are employed or have other means of support

8C   Of youth in foster care who completed a Living Skills Assessment:

        % who are identified as needing self-sufficiency skills training

Indicator 8A involves ILP services and employment upon emancipation. CDSS's ILP is designed to address the exceptional needs of youth aging out of foster care. The services offered through the ILP include skills training in money management, decision making, self-esteem building, and job readiness. Youth in certain counties are also eligible for ILP's Transitional Housing Placement Program, and 52 counties throughout the State are currently contracted with CDSS to provide ILP youth with college and career preparation. All of the services offered through the ILP are tracked throughout the year via year-end narrative reports from the counties. ILP representatives also informed CPPR that counties are required to provide statistical "snap shots" of their activities to CDSS as part of these annual reports. All of these data, however, are aggregated to the county level and would not be useful in addressing indicator 8A. However, both the planning of ILP services (i.e., indicated need) and the actual receipt of such services can be captured through CWS/CMS data elements. To degree to which such information is reliably and thoroughly captured in practice requires further investigation.

Another component of 8A is "employment or other means of support". Although the Employment Development Department (EDD) is part of the larger SIT, they do not have representation in the Core Indicators Workgroup. As a result, no formal meeting took place between CPPR and EDD. EDD was contacted, however, and several useful pieces of information were gleaned. First, the Base Wage File (BWF) is a dataset containing quarterly earnings for all workers in the State who are covered by unemployment insurance. These data are at the individual-level and include SSNs. EDD representatives reported that EDD and CDSS

have a standing contract under which the BWF is provided to CDSS every quarter. Given this, CDSS could gain access to the BWF internally. Alternatively, CDSS could go through the EDD, which would require a formal agreement with EDD's Information Security Office (ISO). Information on adults receiving public assistance would be available through CalWORKs and MEDS, although it is unclear how complete these data would be. In addition, former foster children could very well have "other means of support" not captured by any existing data. In addition, any former CWS youth who have moved out of state would be impossible to track using any of the means listed here.

In terms of indicator 8C, a Living Skills Assessment (LSA) is administered to a youth prior to emancipation. The results of the LSA are then noted in CWS/CMS. Given this, 8C is another example of an indicator that can only be addressed with CDSS data.

Emancipation Issues

8B   Of youth exiting from foster care:

        % with a legal emancipation hearing or termination of jurisdiction hearing

        % with the documents required by AB 636

Both of the outcomes captured by indicator 8B involve whether or not a youth goes through the proper legal channels and formal procedures necessary to achieve emancipation.

In terms of the first component of indicator 8B, CPPR consulted the AOC to determine the availability of data related to emancipation and jurisdiction hearings. The AOC is the staff agency to the Judicial Council of California, the policymaking body of the state Court system. The AOC regularly collects data from all 58 Superior Courts in California, all Courts of Appeal, and the Supreme Courts of California. However, all of the data reported to the AOC is aggregated to the Court level. For this reason, the AOC representative felt the data they maintain would be of limited usefulness in research related to CWS populations. CPPR and AOC representatives also explored the possibility that data of interest may be maintained by the

Courts themselves. Although the AOC representative felt that the courts may have data of interest, these data are unlikely to be accessible in electronic form. Although it may be possible to cull information from Court "paper" records, CDSS would be faced with the option of sampling from one or more superior courts, or of dedicating a great deal of time and human resources to collecting data from all 58 Superior Courts throughout the state. In addition, sampling from several Courts may be problematic in that definitions are not standardized, with Courts, in some cases, displaying differences in how they define dependency data elements. This, however, is one of the issues that the AOC's new California Case Management System (CCMS) will address. The California Blue Ribbon Commission on Children in Foster Care, which includes representation from CDSS and other agencies involved in the Core Indicators Workgroup, is currently in the process of reviewing and recommending dependency court data elements and performance measures to be incorporated into the CCMS. These juvenile dependency and delinquency components of the system are expected to be deployed sometime in 2010. The data reported by local courts to the AOC through CCMS will continue to be aggregate data, however CCMS will result in detailed, standardized case level data on dependency cases in each local court. Ultimately, CMMS will be in a position to provide these data to CDSS, and there is a mechanism in place in the planning stages of CCMS to facilitate such future data exchange.

In terms of the second component of 8B, the documents required by AB 636 are furnished to emancipating youth by their case workers, a fact that can then be entered into CWS/CMS. It is unclear at this point, however, how complete and reliable such data are. What is clear is that such data do not exist outside CDSS, but may be accessible via a survey if CWS/CMS data are found to be insufficient.

Legal Issues

8D   Of youth in foster care:

     % who are on probation or incarcerated

     % who are transferred into the juvenile justice system

The two component outcomes that make up indicator 8D involve a youth's involvement in the legal system. As DOJ is not a member of the Core Indicators Workgroup, no formal meeting with CPPR and DOJ officials took place. However, information was gathered about their relevant data systems via personal communication and written information.

The primary source of individual-level juvenile data is the Juvenile Court and Probation Statistical System (JCPSS). The JCPSS database, which contains information from 1997 to the present, is designed to collect, compile, and report statistical data on the administration of juvenile justice in California. It provides information on a juvenile's process through the juvenile justice system from probation intake to final case disposition, and therefore would be directly relevant to all aspect of indicator 8D (probation, incarceration, and transfer into the juvenile justice system). Although the JCPSS does not maintain SSN as a unique identifier, there are several personal identification variables for matching, including name, gender, DOB, and race/ethnicity. DOJ representatives also noted, however, that there would be significant legal constraints to releasing such juvenile data to CDSS unless de-identified, or unless released under a formal agreement between the two departments.

Summary

Indicators 8A through 8E are primarily composed of variables that can only be addressed with CWS/CMS data, or that can be addressed with a single DOJ database. This DOJ database contains information on probation, incarceration, and other involvement in the juvenile justice system. Information related to various legal hearings, however, does not appear to be available through any source but CWS/CMS. Indicator 8A (which in the *Outcomes and Process Matrix* also includes outcomes related to higher education) is challenging in that the wording "employment or other means of support" is extremely broad and, technically, could include non-traditional sources of income or monetary support that cannot be captured by administrative data. Employment data are available, however, through a dataset to which CDSS already has access.

Recommendations

1. Explore the legal issue involved in the sharing of juvenile justice data. The data maintained by DOJ would be extremely useful in addressing indicator 8D. It is, in fact, the only place these data can be found. It is CPPR's belief that DOJ could provide these data to CDSS either in de-identified form (i.e., after DOJ has performed probabilistic matching with CDSS data, then removed all identifying information), or subsequent to a formal arrangement between the two departments.

2. Explore the reliability and completeness of CWS/CMS emancipation data. The ability to address indicators related to Living Skills Assessments lies with CDSS, and given the lack of individual-level data available from AOC, the ability to determine whether legal emancipation and termination of jurisdiction hearings have taken place might also lie with CWS/CMS. The employment data element that exists within CWS/CMS could also prove useful, although it is not yet known how thorough or timely those data are. One strategy for making that determination would be to check CWS/CMS employment data against employment data from the Base Wage File, then deciding which source is likely to provide the most valid input for this indicator.

VI. CHALLENGES AND LIMITATIONS

In addition to gathering basic information on the existence of various databases and data elements, several important challenges to potential data integration between CDSS and other state agencies were investigated by CPPR. These challenges can be broken down into several broad categories, which will be addressed in turn.

Matching

The primary means by which CDSS identifies individuals in their data systems is social security number (SSN). Of the departments covered in this report, DHS, ADP, and AOC also maintain SSN. DMH identifies individuals through the nine-digit Client Identification Number (CIN), which is also included in the MEDS database. CDE tracks individuals by Student Identification Number (SSID), and DDS by a seven-digit Unique Client Identifier (UCI).

Each department acknowledged that the processes by which these identifiers are assigned and maintained are not perfect. Duplications, errors, and omissions exist in most of the datasets discussed in this report. This—combined with the fact that there is no common identifier linking all of the departments—would make probabilistic matching a necessity if data from multiple departments were ever to be combined. In cases of large administrative datasets, probabilistic matching is most often accomplished by the creation of executable algorithms within statistical software programs (e.g., SAS, SPSS), matching an individual's data from one dataset to their information in another through a range of demographic and personal information (gender, date of birth, mother's name, address, etc.) Matching in this manner is common in research and administrative settings, but can also be challenging. To achieve the highest degree of accuracy, additional "hand matching" is often required (i.e., locating or reviewing matches record-by-record). Such hand matching requires a great deal of time and human resources, particularly when dealing with large datasets.

Confidentiality/HIPAA Issues

Throughout discussions of data integration, both CPPR and agency representatives were highly concerned with issues of confidentiality. Due to regulations set out in the 1996 *Health Insurance Portability and Accountability Act* (HIPAA), DMH and DHS must comply with Federal privacy protection regulations related to individually identifiable health information. HIPAA regulations apply to three types of "covered entities," including health plans, health care clearinghouses, and health care providers who conduct certain health care transactions electronically. DMH and DHS are both covered entities, while DDS is not. This limits the type of individual-level data that either agency may provide to CDSS.

That said, representatives from both agencies acknowledged the possibility of internal (i.e., within DMH or DHS) data matching that would not violate HIPAA (nor the more extensive confidentiality rules associated with alcohol and drug-related data.). Such integration would most likely involve CDSS providing a list of individuals to the agencies (e.g., lists of all CWS children and parents of interest), after which the agencies would (1) identify such individuals within their data sets via probabilistic matching on demographic variables, (2) de-identify the matched data using a unique numerical code, and (3) provide CDSS with a new data file containing individual-level mental health service data listed by these new codes. As mentioned in Section II, collaborating with DHS could also involve their provision of complete analyses of the indicators of interest, rather than release of the data themselves.

In terms of CDE data, the Family Education Rights and Privacy Act of 1974 (commonly known as FERPA) is a federal law that protects the privacy of student education records. Any record that contains personally identifiable information that is directly related to the student is an educational record under FERPA. The exchange of such information, therefore, would need to adhere to the guidelines set out in law. In discussing FERPA issues with CDE representatives, several preliminary conclusions were drawn: (1) that the privacy of student educational records is of great importance to CDE; (2) that CDE is willing to work within FERPA guidelines to facilitate the exchange of information with CDSS; (3) that CDE has successfully exchanged

student-level data with other California state agencies in the past; and (4) that data integration and exchange could likely be accomplished in several ways, including in-house exchange (i.e., data integration and de-identification within CDE), under contract, or through the use of a Memo of Understanding (MOU) between CDE and CDSS.

Reliability

Questions of reliability will ultimately need to be assessed on a variable by variable basis. As the aim of the current project was to conduct preliminary investigations and report descriptive information, that level of reliability cannot be addressed at this time. In many cases, even if CPPR had been able to provide agency representatives with a detailed list of variables of interest, definitive answers on reliability (i.e., reliability based on statistical analyses or other formal criteria/scaling) would not have been available. That said, several general comments can be made about the quality of the data maintained by some departments. This information is not available for all of the databases discussed in this report, as only a small number of agency representatives were able to comment on reliability to any significant degree.

CDE reports that the majority of data quality issues are resolved at the local level, so that the data are assumed to be valid and free of major errors by the time they arrive at CDE. Districts must resolve major errors and pass validation tests before transmitting their data to CDE. In addition to Visual Basic, other data quality technologies in use at the local and district levels are SQL Server stored procedures and various data checking procedures available through statistical software (SAS, SPSS, etc.)

Although ADP representatives were unable to quantify reliability, they did feel that the new CalOMS system is robust. Data must have a certain degree of integrity before being sent up from counties and providers. For example, null values are not allowed for the majority of variables. ADP representatives were not certain, however, as to the degree of validity checking that may or may not occur at the county level. For this reason, incorrect or dummy social

security numbers may exist in the system. In addition, clients entering substance abuse treatment may be reluctant to answer many of the questions related to CalOMS data elements.

As with other departments, the reliability of the data in the DDS databases depends on the quality of data as entered by individual case workers at the 21 Regional Centers. Given that the Regional Centers have their own policies and procedures regarding data entry (e.g., frequency, completeness), the reliability of the data likely varies across Regional Centers. Another challenge to obtaining sufficient reliability of DDS data is that the electronic databases in which case workers enter their data contain many data elements that are optional, rather than mandatory (e.g., diagnosis). Thus, the data for these data elements are likely incomplete and biased by unknown factors.

VII. CONCLUSIONS AND RECOMMENDATIONS

In summary, CPPR has determined the following:

1. Data are available within CDSS or other SIT member agencies to adequately address 18 of the 33 outcomes.

2. Data are available within CDSS or other SIT member agencies to partially address 4 of the 33 outcomes.

3. Data are not available within any of the state agencies investigated by CPPR to address 11 of the 33 outcomes.

A tabular breakdown of these findings can be found in Tables 1 to 3 (p. 52-55). Table 1 (dark gray) list the AB 636 well-being indicators for which data are currently available, Table 2 (light gray) lists those for which data are partially available, and Table 3 (striped) lists those for which no data currently exist at the state level within CDSS or any of the SIT member agencies with which CPPR met. The tables also provide information on the location of the data that were found to be relevant, any contingencies or limitations uncovered by CPPR, and any alternative locations in which the data might reside.

Table 1. AB 636 indicators for which data are available

	INDICATOR	DEPT	DATA SET(S)	CONTINGENCIES/ LIMITATIONS	ALTERNATIVE LOCATION(S)
Health and Mental Health					
5A	% of children in care more than 30 days with a Health Passport	DSS	CWS/CMS	Timeliness and completeness of HEPs	---
5B	% of children in care with CHDP that comply with periodicity table	DHS	MEDS	Utilizing DHS's data request procedures	Directly from CHDP, rather than Medical Statistics Center
	% of children in care with dental exams that comply with periodicity table	DHS	MEDS	Utilizing DHS's data request procedures	Directly from CHDP, rather than Medical Statistics Center
	% of children in care with immunizations that comply with periodicity table	DHS	MEDS	Utilizing DHS's data request procedures	Directly from CHDP, rather than Medical Statistics Center
5D	Family maintenance children receive Health Passports and screenings	DSS	CWS/CMS	Timeliness and completeness of HEPs	---
5E	% of children in care who receive an initial mental health screening within 30 days of initial placement	DHS	MEDS	Utilizing DHS's data request procedures	Directly from CHDP, rather than Medical Statistics Center
Education					
6A	% of children in care more than 30 days with a Health and Education Passport	DSS	CWS/CMS	Timeliness and completeness of HEPs	---
	% of children in care more than 180 days with a Health and Education Passport	DSS	CWS/CMS	Timeliness and completeness of HEPs	---
6B	% of children with an IEP	CDE	CASEMIS	Data updated in June and December	---
	Of children with an IEP, % who receive services	CDE	CASEMISS	Data updated in June and December	---

	INDICATOR	DEPT	DATA SET(S)	CONTINGENCIES/ LIMITATIONS	ALTERNATIVE LOCATION(S)
6B	% of children performing below grade level	CDE	STAR	Need to determine what tests/scores best reflect performance "at grade level"	---
6D	% of children enrolled in the same school	CDE, CDSS	CWS/CMS combined with CALPADS	Timeliness and completeness of enrollment info in CWS/CMS	---
6E	% of children in care at grade level on standardized state tests	CDE	STAR	Need to determine what tests/scores best reflect performance "at grade level"	---
8A	Of youth emancipating from foster care, % with high school diploma or GED	CDE	CALPADS	---	Survey
Emancipation and Legal Involvement					
8A	% who are employed or have other means of support	EDD DSS	Base Wage File CalWORKs	Would not capture non-traditional means of support; CA employment only	CWS/CMS
8C	% who are identified as needing self-sufficiency skills training	DSS	CWS/CMS	Thoroughness and reliability of the data in CWS/CMS	---
	% who are on probation or incarcerated	DOJ	JCPSS	---	CWS/CMS
8D	% who are transferred into the juvenile justice system	DOJ	JCPSS	---	CWS/CMS

Table 2. AB 636 indicators for which data are partially available

	INDICATOR	DEPT	DATA SET(S)	CONTINGENCIES/ LIMITATIONS	ALTERNATIVE LOCATION(S)
Health and Mental Health					
5B	% of children in care with psychotropic medication consultations	DHS	MEDS	Utilizing DHS's standard data request procedures	Directly from CHDP, rather than Medical Statistics Center
5C	% of CWS children with mental health referrals who receive mental health services	DHS	MEDS	Ability to tie services to referrals; existence of referral data in MEDS; will not capture mental health services embedded within more comprehensive provider contact	Referral information from CHDP
		DMH	CSI		---
Education					
6B	% with school changes during the year	CDE	CALPADS combined with STAR	The existence of reliable school IDs in STAR data; would only allow determination of no vs. one or more changes; CALPADS tracking is only as reliable as the due diligence LEAs exercise in updating the *Student Locator System*	CWS/CMS (HEP forms)
Social Support					
7A	% of parents able to access and use support services identified in case plans, by case closure	DSS, DDS, AOD	Dependent on support services of interest	Greater degree of specificity in the wording of the indicator	Survey

Table 3. AB 636 indicators for which data are not available at this time

	INDICATOR	DEPT	DATA SET(S)	CONTINGENCIES/ LIMITATIONS	ALTERNATIVE LOCATION(S)
Education					
6B	# of school changes during the year	CDE	---	---	CWS/CMS (HEP forms)
6C	% of school aged children enrolled within 1, 2, 3, and 4 weeks or more of initial out-of-home placement	CDE	---	---	CWS/CMS (HEP forms)
	% enrolled within 1, 2, 3, and 4 weeks of placement change	CDE	---	---	CWS/CMS (HEP forms)
6D	% with adequate yearly attendance	CDE	---	---	---
	# of school days missed	CDE	---	---	---
	% in non-public schools	CDE	---	---	CWS/CMS (HEP forms)
8A	% enrolled in college or higher education program	CDE	---	---	Survey
	% who complete vocational training program	CDE	---	---	Survey
Emancipation and Legal Issues					
8A	% with receipt of Independent Living Program (ILP) services	DSS	CWS/CMS	Thoroughness and reliability of the data in CWS/CMS	---
8B	% with a legal emancipation hearing or termination of jurisdiction hearing	AOC	---	---	CWS/CMS
	% with the documents required by AB 686	DSS	CWS/CMS	Thoroughness and reliability of the data in CWS/CMS	Survey

Many of the indicators are related to data collected by CDSS's CWS/CMS system, whereas a large proportion of the remaining variables are related to health and education services provided by DHS and the CDE. It was clear from the discussions with the agency staff that data are available; however, they are not always available at the child level, but rather at high levels of aggregation.

As mentioned above, a significant proportion of the outcomes can be addressed using DHS data systems, specifically the database maintained by the *Child Health and Disability Prevention* (CHDP) program, which ultimately feeds into the Medi-Cal Eligibility Data System (MEDS). DHS representatives expressed a strong desire to work with CDSS, not only in relation to CWS children, but to the broader population of Californians served by both departments. Short of such future collaborations, it was DHS's express recommendation that CDSS go through existing formal data request procedures so that experts from DHS's *Center for Health Statistics* (CHS) can locate CWS children in the database, identify the variables of greatest interest, and attempt to provide quantitative results for these health and mental health indicators. DHS also suggested that, as a first step, CDSS could provide them with a sample list of Social Security Numbers (SSNs) for CWS children, and that list could serve as a "test run" to give both departments a better idea of how straightforward or challenging it will be to locate and analyze the necessary data.

CDE also houses data related to many of the well-being indicators and is eager to work with CDSS, in large measure due to their own desire to locate and track foster children in their data systems. If CDSS could provide CDE the information necessary to do this, CDE could, in turn, provide the data needed to address indicators related to school enrollment, school performance, Individualized Education Plans and services, and high school graduation.

Each of the other departments with which CPPR met not only expressed support for this project, but house data that may be relevant to AB 636 issues. As will be seen throughout this report, those data are primarily related to indicator 7A (support services), which was written to

be broad and inclusive. Following future clarification of this indicator, the data held by other SIT member agencies may prove more or less vital to CDSS's mission.

Finally, although further details were discussed in the body of this report, it should be noted again that issues related to data integration and confidentiality were discussed with all departments. Such issues are often discussed as "road blocks" to the sharing of administrative data between government agencies. It is CPPR's belief, based on our research, that these difficulties are not insurmountable. All of the key databases CPPR located contain adequate demographic information to perform probabilistic matching (even without the existence of common unique identifiers), and there are several ways to approach legal barriers related to confidentiality. Internal merging and de-identification can be performed prior to data release to CDSS, contracts or Memos of Understanding (MOUs) can be set up between CDSS and other departments, or analyses can take place within other departments (e.g., DHS) and CDSS can then be given analysis results rather than raw data.

As any of these approaches will require a fair degree of time and human resources, the next step for CDSS and other SIT member agencies is to reach an agreement on where those human resources will come from, what current or future personnel would be needed, and whether further funding will be necessary. Addressing the AB 636 indicators *once* will require a certain degree of commitment; setting up a process by which the tracking and sharing of data related to CWS children can take place regularly, efficiently, and more thoroughly than possible at the present time will take a long-term commitment from HHSA and several of its constituent agencies.

Recommendations

CPPR's primary goals for this project were to provide CDSS with descriptive information on state agency data systems, to discuss the possibilities that data from these systems could be used to address AB 636 indicators, and to provide broad recommendations as to how CDSS might best proceed in their quest to facilitate the assessment of well-being. The following, then,

are those broad recommendations. Although ordered here to indicate some degree of suggested priority, this ordering is not meant to signify a requisite chronological sequence. Indeed, many of the action steps embedded in the recommendations can and should be undertaken simultaneously, while others might require an iterative approach (i.e., doubling back to certain action steps as progress occurs in other areas). Implementation of the majority of these recommendations will also require significant interdepartmental cooperation, and the pooling of data and programmatic expertise from a number of the agencies that provide critical, ongoing services to CWS children.

In the short term CPPR recommends the following:

1. **REVISIT THE AB 636 WELL-BEING INDICATORS.**

    The 15 indicators written by the Accountability Workgroup were designed with best practices in mind, rather than the existence of the data needed to operationalize them. Although CPPR supports the Workgroup's efforts to be broad and inclusive in their discussions of well-being, advancement from this point would be aided by a thorough review of these indicators. Such a review should be undertaken with an eye toward improving their clarity and specificity, and determining which indicators are the most crucial to pursue at this time.

    In terms of clarity and specificity, there were many instances in CPPR's investigation process when it was difficult for agency representatives to determine whether the indicator could be addressed because the dependent variable in question was unclear. Indicator 7A, for example, reads: "Percent of parents able to access and use the support services identified in case plans." This indicator could cover a wide array of services, some of which are overseen by the agencies involved in this report, some of which are not. In other cases, the dependent variable was clear (e.g., students should be performing "at grade-level"), but there is no indication in the indicator's wording as to how the committee would like grade-level to be measured. To proceed, therefore, each

and every indicator should be further clarified, given a time frame if necessary (i.e., "within 30 days"), and further elucidated in terms of intent.

In regard to prioritization, it became clear during the course of CPPR's investigations that there are a number of indicators for which data are readily available, and a number for which data simply do not exist in any state agency at this time. For this reason, it might prove useful to separate indicators into (a) those that should be pursued immediately, (b) those that will require longer-term efforts, and (c) those that would require a large (perhaps prohibitive) amount of time and human resources to pursue. Once the indicators are clarified, pared down, and prioritized, short- and long-term strategies will become more evident.

2. **DECIDE UPON THE DEGREE TO WHICH SAMPLING IS OR IS NOT ACCEPTABLE AS A STRATEGY FOR ADDRESSING THE INDICATORS.**
CDSS currently conducts a statistically valid annual survey of birth and foster parents to obtain well-being information specific to assessment for and receipt of educational, health, and mental health services. Consideration should be given, therefore, to the feasibility of adding items regarding perceived *access* to these support services (e.g., as reflected in indicator 7A), as such information is unlikely to be accessible in any administrative database. Similarly, there are several education-related indicators that cannot be matched at the individual level and do not exist at the state level, but may be accessible in some form at the district level. A crucial next step for CDSS, therefore, would be to reach a definitive agreement (either internally or with state or federal officials) on whether or not it would be acceptable under the new outcomes and accountability system to address some of the indicators via a representative sample of specific groups.

3. **IMPROVE THE PROCESSES BY WHICH DATA ARE GATHERED, ENTERED, AND ANALYZED IN CDSS'S CHILD WELFARE SYSTEM/CASE MANAGEMENT SYSTEM (CWS/CMS).**

Currently, any new well-being measure developed by CDSS's AB 636 data subcommittee is accompanied by an *All County Information Notice* to provide county child welfare agencies specific instruction for entering information into CWS/CMS. It is anticipated that this practice will result in more consistent information being entered into the system, therefore making the data more reliable. If improvements continue to be made in the thoroughness and reliability of CWS/CMS data, it is theoretically possible for CDSS to address at least 14 of the 33 outcomes investigated by CPPR—with data from other state agencies, perhaps, serving to augment or validate this CWS/CMS information.

It should also be noted that several of the current well-being indicators are specifically geared toward CWS/CMS processes and would therefore be unavailable from any other state agency. For example, there are three indicators dealing with the maintenance of Health and Education Passports (HEPs). As HEPs are generated by the CWS/CMS system, the ability to determine the percentage of children for whom this was accomplished lies exclusively with CDSS. There are also several indicators related to health and mental health (particularly dental and vision exams, mental heath screenings and referrals, and immunizations) that deal with information that is required to be entered into a foster child's HEP. Although those data may be available through DHS, there is already a system in place for the transfer of all of this information back to case workers. It is CPPR's recommendation, therefore, that the reliability and thoroughness (i.e., the usability) of CWS/CMS data continue to be investigated, followed by an analysis of the causes of any shortcomings that are found (i.e., whether it is timeliness, accuracy, and/or thoroughness that are of issue). With more in-depth information on what is and isn't available in CWS/CMS and why, CDSS would be better positioned to

make decisions on the efficiency of (a) undertaking internal improvements, versus (b) pursuing external data.

In the longer term CPPR recommends the following:

1. **FURTHER INVESTIGATE ISSUES RELATED TO DATA INTEGRATION AND CONFIDENTIALITY.**

   Most if not all of the agency representatives involved with this report cited confidentiality as a concern in terms of data sharing among departments. Analysis must therefore be completed to determine what can and cannot be shared across agencies, and the most feasible and responsible strategies for working within current data confidentiality guidelines. These strategies may include the conducting of surveys, de-identification of individual clients, or the sharing of aggregate information between departments. Further discussion can be found in the body of this report.

2. **ESTABLISH MOU'S WITH THE DEPARTMENTS OF HEALTH (DHS), MENTAL HEALTH (DMH), AND EDUCATION (CDE).**

   Along with CDSS, the data possessed by DHS, DMH, and CDE are the most relevant to the AB 636 well-being indicators. In the course of CPPR's investigations, all of these departments expressed a keen interest in collaborating with CDSS to locate and track CWS children in their own systems. Representatives from DHS also expressed a strong desire to work with CDSS on issues above and beyond AB 636, noting the high degree of overlap in the adult and child populations served by both departments.

3. **INVESTIGATE THE POSSIBILITIES OF CREATING A CENTRALIZED DATA WAREHOUSE**.

   Centralized integration of administrative data from multiple government agencies is both the most challenging and, ultimately, most promising strategy for tracking the movement of individuals over time and across service categories. States have long investigated the feasibility of integrating existing databases in a central location, either

once (for the purposes of one-time research or evaluation) or in an on-going fashion. The latter approach would enable independent evaluators and/or the agencies themselves to ask and answer a range of questions about the individuals served. In terms of CDSS's current attempts to track the well-being of CWS children, data warehousing could either be limited to the specific variables determined to be directly relevant to the tasks of matching and outcome analysis; or the approach could be more ambitious, feeding entire de-identified datasets into a centralized location on an on-going basis. There are many challenges to either approach. First, agency data systems would need to be analyzed to a deeper degree than was possible in the current project. Second, once multiple agencies agreed to participate in the project and performed these preliminary variable-level analyses, issues of system compatibility, database structure, record formatting, and storage capacity would need to be analyzed, most likely with the help of independent technical consultants who have experience working with large administrative datasets. Confidentiality would also be of paramount importance in any warehousing arrangement, with the data needing to be de-identified and/or the security of the server assured. Finally, issues of reliability, linkage, and coding schemes would present further challenges and would require the ongoing commitment of all involved agencies. Several states have included the investigation of data integration in their Program Improvement Plans (PIPs) and several California counties have already attempted the warehousing of cross-agency data. Analyses of their experiences could prove extremely valuable.

APPENDIX A

Outcomes and Process Matrix

C-CFSR Outcomes and Indicators

Child & Family Well-Being Outcomes	Indicators			
	Federal	State Enforced	Short-term Development	Future Development
5. Children receive adequate services to meet their physical, emotional and mental health needs.	Source: No quantifiable measure available; obtained during review of 50 cases statewide.		5A. Health Information: Percent children in care more than 30 days with a Health Passport. 5B. Receipt of Health Screenings: Percent children in care with CHDP, dental exams, psychotropic medications, and immunizations that comply with periodicity table. NOTE: 5A and 5B dependent on CWS/CMS system changes to identify children who do not have health, medication needs in order to calculate the % who should have information on specific health factors. 5C. Receipt of mental health services among CWS children with mental health referrals: Percent of CWS children with mental health referrals who receive mental health services. Stratify by in-home versus out-of-home care. NOTE: Calculation dependent on clarification and revisions to CWS/CMS referral types.	5D. Prevention services: FM Children receive Health Passport and screenings. 5E. Receipt of mental health screening: Percent of children in care who received an initial mental health screening within 30 days of initial placement.

C-CFSR Outcomes and Indicators

Child & Family Well-Being Outcomes	Indicators			
	Federal	State Enriched	Short-term Development	Future Development
B. Children receive appropriate services to meet their educational needs.	Source: No quantifiable federal measure available; obtained during review of 50 cases statewide.		6A. Education information: % in care more than 30 days with an Health Education Passport, and % in care more than 180 days with a complete HEP. 6B. School stability: For children in out of home care for one or more school years: * % with school change during year, and # of school changes * % of children with IEP. * % of children performing below grade level	6E. School performance: Percentage of children in care at grade level on standardized state tests (requires match to planned statewide education data; stratified by special and regular education (by entry cohort, age, and placement type).

Child & Family Well-Being Outcomes	Indicators		Short-term Development	Future Development
	Federal	State Enriched		
			6C. School enrollment: • % of school aged children enrolled within 1, 2, 3, and 4 weeks or more of initial out-of-home placement. % enrolled within 1, 2, 3, and 4 weeks of a placement change. NOTE: Dependent on improvement of mechanism to obtain information from schools and document it in CMS. **6D. School stability, attendance:** • % with adequate (TBD) yearly attendance • # of school days missed • % in non-public schools • % of children enrolled in the same school • Of those children with an IEP, % who receive services NOTE: 6D unavailable via CWS/CMS, and would require data match with education. May require MOU w/ CDE or statutory change.	

67

C-CFSR Outcomes and Indicators

Child & Family Well-Being Outcomes	Indicators		
	Federal	State Enriched	
		Short-term Development	Future Development
7. Families have enhanced capacity to provide for their children's needs.	Source: No quantifiable federal measure available, obtained during review of 50 cases statewide.	7. Receipt of support services: Percentage of parents able to access and use support services identified in case plans, by case closure. NOTE: Post exit survey needed to access 7.	

Child & Family Well-Being Outcomes	Federal	Indicators		
		State Enriched	Short-term Development	Future Development
B. Youth emancipating from foster care are prepared to transition to adulthood.		**8A. Transition to self-sufficiency:** Of youth emancipating from foster care, the percentage [*]: • with High School diploma or GED • enrolled in college or higher education program • with receipt of ILP services • who completed a vocational training program • are employed or have other means of support NOTE: Data source for this measure is the County ILP report. This data is subject to the limitations of the data reporting form. RECONCILE THIS LIST W/ NATIONAL STANDARDS TO BE RELEASED BY ACF (ie, Chafee requirements and probation)	**8B. Transition to self-sufficient adulthood:** Of youth exiting from foster care, the percentage [*]: • with a legal emancipation • leaving or termination of jurisdiction hearing • with the documents required by AB 606 **8C. Self-sufficiency skills training:** Of youth in foster care, who completed a Living Skills Assessment, the % who are identified as needing self sufficiency skills training. NOTE: 8C is contingent upon revision of Transitional Independent Living Plan form and changes to CWS/CMS.	**8D. Probation or juvenile justice:** Of youth in foster care, the percentage [*]: • who are on probation or incarcerated[*] • who are transferred into the juvenile justice system. NOTE: This measure would require a data match to the Department of Corrections.

APPENDIX B

Departmental Reports

STATE INTERAGENCY TEAM (SIT)

Initial Findings from the California Department of Mental Health

On May 15, 2006, a meeting took place between Center for Public Policy and Research (CPPR) staff and representatives from the California Department of Mental Health (DMH). Attendees from each agency were as follows:

Department of Mental Health
Tom Wilson, Research Manager, Statistics and Data Analysis
Mark Wiederanders, Research Program Specialist
Brenda Golladay, Research Program Specialist
Sara-Jane Gilb, Research Program Specialist

Center for Public Policy Research
Gail S. Goodman, CPPR Director/PI
Michael Lawler, CPPR Co-PI
Kate Wilson, Research Writer
Saroja Subrahmanyan, Quantitative Analyst
Christin Ogle, Research Analyst
Joshua McCabe, Administrative Assistant

The primary purpose of this initial meeting was for CPPR to gather information on DMH data systems, specifically databases containing information relevant to the AB636 child well-being indicators proposed by the California Department of Social Services (CDSS) for use in their federally mandated *Child and Family Services Review* (CFSR). CPPR's goals for this meeting were as follows:

- To identify information available on AB636 issues, particularly those related to mental health and mental health services for children, parents, and other caretakers involved with California's child welfare services (CWS);
- To make an initial assessment of the possibilities for data integration and shared data management between DMH and CDSS.

Although numerous outcome areas are covered by CDSS's child well-being indicators, it was anticipated that four of the fifteen indicators would be of particular relevance to DMH:

- Percent of children in care who receive an initial mental health screening within 30 days of initial placement;
- Percent of CWS children with mental health referrals who receive mental health services, stratified by in-home vs. out-of-home care;
- Percent of children in care with psychotropic medications that comply with periodicity table; and

- Percent of parents able to access and use support services identified in case plans, by case closure.

Overview of Findings

Although a more detailed analysis of both CDSS and DMH databases would be needed to provide a definitive answer on the possibility of data integration, the current report provides a general overview of findings. This includes brief descriptions of the primary databases maintained by DMH, and an initial evaluation of the availability of data related to each of the mental health indicators listed earlier.

The following are brief descriptions of data systems maintained by DMH, listed in order of potential relevance to the AB636 child well-being indicators. (Note: Descriptions have been adapted from the document, *County Mental Health Data Systems Maintained by the California Department of Mental Health*, which was provided to CPPR by DMH.)

Client and Service Information System (CSI)
The CSI is a statistical information system that includes data on all persons served in county mental heath programs in California. There are three types of records reported to CSI:

(1) client records, which include client characteristics, such as date of birth, race/ethnicity, and language;
(2) service records, which include information about the service encounter, such as date of service, type of service, and diagnosis; and
(3) periodic records, which include types of client data that are collected less frequently, such as living situation and employment status.

CSI data are reported monthly by county programs via DMH's *Information Technology Webserver* (ITWS). Summary statewide and county reports are also sent back to counties via the ITWS.

Medi-Cal Eligibility Data System (MEDS)
Each month, the Department of Health Services (DHS) provides a copy of the MEDS Monthly Extract File to DMH. The files include all persons who are eligible for Medi-Cal services for the current month, as well as eligibility history for the previous 15 months. DMH, in turn, provides this file to each county for the persons eligible from that county. The file includes extensive information, but is primarily used by DMH to explore demographic data on the number of eligibles by county, and by other characteristics of interest. The data are later combined with client counts to develop access/penetration rates.

Short-Doyle Medi-Cal Approved Claims (SD/MC)
Counties submit claims through the ITWS to DMH for services provided by county mental health and contract providers. DMH, in turn, submits the claims to DHS for processing in a separate system known as Short-Doyle/Medi-Cal. DHS approves the claims and provides a file

back to DMH on the approved or denied status of the claims. These files are then provided back to the counties. The claims include information identifying the client, the services provided, diagnosis, amount claimed, and amount approved.

Therapeutic Behavioral Services (TBS)
In 1999, a separate data set was established in response to a court order to collect information on youth receiving therapeutic behavioral services. The data set includes information notifying DMH that the county expects to provide specific services to individuals for a designated time period. Recently, the court ordered that the data systems be continued for another 18 months.

Performance Outcomes Data System (PODS)
The Performance Outcomes Data System contains performance measurement data typically collected through a consumer survey process at the local department/provider level. Data records include consumer perception of care information, which is assessed using the Mental Health Statistics Improvement Program (MHSIP) consumer survey (for adults and older adults) and the Youth Services Survey (for youth and parents/guardians). Data records also contain some demographic information and (for adults) data on quality of life indicators. Consumer perception data are currently collected on a sample basis, typically during two-week periods annually or semi-annually.

Outcome-by-Outcome Assessment
As noted above, the well-being indicators relevant to DMH cover several key areas:

- the receipt of mental health screenings,
- the receipt of mental health services for children with mental health referrals,
- the receipt of services related to psychotropic medications, and
- the ability of parents to access support services identified in their child/foster child's case plan.

In this section, the availability of data on each of these topics will be reviewed. Following this, Table 1 (p. 7) provides a summary of the anticipated availability/location of data relevant to each of the indicators related to mental health and mental health services.

Screenings and Referrals
In reviewing these two outcome areas, DMH representatives determined that data related to mental health screenings and mental health referrals are not maintained by their department, but may be available from county mental health organizations.

One issue that arose, however, was the question of what constitutes a "screening" or a "referral" for the purposes of these indicators. For example, it was unclear whether CDSS is specifically (or exclusively) interested in screenings and referrals that take place through (or result from) the Department of Health Services' *Child Health and Disability Prevention Program* (CHDP).

Regardless, it was anticipated by both CPPR and DMH staff that this information is most likely to exist in hard copy in a child's case file, or in CDSS's *Child Welfare Services/Case Management System* (CWS/CMS).

Mental Health Services
Data related to mental health services are available through DMH, primarily in the CSI and SD/MC databases. DMH representatives felt that CSI contains more complete records of mental health provider contacts, as the MEDS extract file only reflects paid claims. CSI does not have that restriction, containing information on all services regardless of payor.

DMH also noted that the term "services" could be applied to a wide range of provider contacts —everything from routine medication consultations to involuntary detention in drug rehabilitation facilities. To properly assess this indicator, therefore, CDSS (perhaps with the assistance of DMH representatives) would need to determine which particular services would be appropriate to capture based on the *intent of the indicator* as it is currently written.

Stated another way, given that the indicator specifically relates mental health *services* to the mental health *referrals* that prompted them, one challenge when assessing this indicator would be the proper identification of provider contacts related to a CWS child's documented needs, as opposed to services that resulted from unrelated emergencies, newly emerging mental health conditions, substance abuse, etc. Once these issues are clarified, DMH representatives would be able to identify which particular variables or service codes within CSI could be utilized in the assessment of this indicator.

Psychotropic Medications
Data related to the receipt of psychotropic medication evaluations are partially available through DMH databases. Both CSI and the Short-Doyle Medi-Cal dataset contain a service category for "Medication Support."

One challenging aspect of this indicator, however, is that many medication consultations take place during more comprehensive visits with either mental health providers or general practitioners. Unless specifically coded as a medication-related visit, many CWS children whose medications *are* being assessed would be missed if DMH data are exclusively relied upon.

DMH representatives also suggested that more useful data related to psychotropic medication may reside within the "Pharmacy File" maintained by DHS. CPPR has not yet determined the accessibility or usefulness of this database.

Support Services
In addition to the specific mental health-related indicators listed on p. 1, CPPR also determined that information contained within DMH's *Performance Outcomes Data System*
may be relevant to the following CDSS child well-being indicators:

- Percent of parents able to access and use support services identified in case plans.

Contained within DMH's *Performance Outcomes Data System* are the results of the department's annual *Mental Health Statistics Improvement Program*, a consumer survey for adults and older adults, as well as results of the annual *Youth Services Survey* for youth and/or parents/guardians. Both surveys assess issues of availability, accessibility, and satisfaction with mental health services provided by the county.

In terms of the data's ability to address the indicator, two issues are relevant: (1) Both surveys are administered to a convenience sample of adults and families receiving mental health services through county providers; and (2) the indicator relates to "support services" broadly, rather than to mental health services in particular.

Challenges/Limitations

In addition to gathering basic information on the existence of various database and data elements, several important challenges to potential data integration between CDSS and DMH were discussed. These challenges/limitations can be broken down into several broad categories.

Matching Issues

The primary means by which DMH identifies individuals throughout its data systems is the County Case Number (CCN). As of July 2006, the Client Identification Number (CIN) has also been added to the system. THE CIN is a 9-digit alphanumeric character supplied from data created in the Statewide Client Index (SCI) system. CINs are shared across all programs participating in the use of SCI (including Medi-Cal, Healthy Families, and California Children's Services) and are crossed-referenced to MEDS IDs in the MEDS system. DMH is aware, however, of problems related to CINs within the SCI data systems, for example, the existence of individuals who have mistakenly been issued multiple CINs (creating duplications in the databases).

In addition, although the CSI and SD/MC databases include a variable for Social Security Number (SSN), DMH representatives noted a history of problems matching CDSS client-level data to DMH data, in that individuals in CDSS data systems may sometimes have no SSN, an incorrect SSN, or a "dummy" SSN assigned to them by case workers. In some cases, these dummy SSNs may be assigned to individuals who have no official SSN by case workers, as the case worker attempts to bypass or "work around" the mandated SSN field within CWS/CMS. These issues of missing and incorrect SSNs would pose a significant challenge to any attempts to match CDSS and DMH data using SSN as the unique identifier.

As an alternative to matching through a unique identifier, however, DMH acknowledged that their data systems do contain a range of demographic variables (such as name, gender, date of birth, mother's name, and address) that could be used for the purpose of probabilistic matching. In cases of large administrative datasets, probabilistic matching is most often accomplished by the creation of executable algorithms within statistical software programs (e.g., SAS, SPSS).

DMH representatives also noted, however, that matching data in this manner is challenging and often requires additional "hand matching" to ensure accuracy (i.e., locating or reviewing matches record-by-record). Such hand matching requires a great deal of time and human resources, particularly when dealing with large datasets.

Confidentiality/HIPAA Issues
Throughout discussions of data integration, DMH representatives were highly concerned with issues of confidentiality. Due to regulations set out in the 1996 *Health Insurance Portability and Accountability Act* (HIPAA), DMH must comply with Federal privacy protection regulations related to individually identifiable health information. HIPAA regulations apply to three types of "covered entities," including health plans, health care clearinghouses, and health care providers who conduct certain health care transactions electronically. The Department of Mental Health, therefore, is a covered entity, while the Department of Social Services is not. This limits the type of individual-level data that DMH may provide to CDSS.

That said, DMH representatives acknowledged the possibility of internal (i.e., within DMH) data matching that would not violate HIPAA. Such integration would most likely involve CDSS providing a list of individuals to DMH (e.g., lists of all CWS children and parents of interest), after which DMH would (1) identify such individuals within their data sets via probabilistic matching on demographic variables, (2) de-identify the matched data using a unique numerical code, and (3) provide CDSS with a new data file containing individual-level mental health service data listed by these new codes.

Conclusions
To summarize, CPPR's initial assessment of the availability of DMH data related to CDSS's well-being indicators is as follows (next page):

Table 1. Summary of DMH Findings

Indicator	Data Within DMH	Alternative Locations	Limitations
% of children in care who receive an initial mental health screening within 30 days of initial placements	No	CWS/CMS or provider level	Reliability of the variable within CWS/CMS
% of CWS children with mental health referrals who receive mental health services, stratified by in-home vs. out-of-home care	Referrals – No Services – CSI, and/or MEDS	CWS/CMS or provider level	The identification of services specifically related to the needs indicated by the referral Would not include services paid for out-of-pocket or through private insurance.
% of children in care with psychotropic medications that comply with periodicity table	CSI and Short-Doyle Medi-Cal	CWS/CMS or provider level Potentially in DHS Pharmacy File	Reliance on DMH data would not capture children receiving medication evaluations by non-mental health providers. Would not include services paid for out-of-pocket or through private insurance.
% of parents able to access and use support services identified in case plans, by case closure	Access and Satisfaction – Partially in PODS	Unknown	Only relates to access and satisfaction with mental health services Data gathered through convenience sampling

77

STATE INTERAGENCY TEAM (SIT)

Initial Findings from the California Department of Education

On May 23, 2006, a meeting took place between Center for Public Policy and Research (CPPR) staff and representatives from the California Department of Education (CDE) and the California Department of Social Services (CDSS). Attendees from each agency were as follows:

> Center for Public Policy Research
> Gail S. Goodman, CPPR Director/PI
> Michael Lawler, CPPR Co-PI
> Kate Wilson, Research Writer
> Gary Stockdale, Quantitative Analyst
> Joshua McCabe, Administrative Assistant

> Department of Education
> Sonya Edwards, Education Administrator

> Department of Social Services
> Ellie Jones, Chief, Children's Services Operations Bureaus

The primary purpose of this initial meeting was for CPPR to gather information on CDE data systems, specifically databases containing information relevant to the AB636 child well-being indicators proposed by CDSS for use in their federally mandated *Child and Family Services Review* (CFSR). CPPR's goals for this meeting were as follows:

- To identify information available on AB636 issues, particularly those related to education for children involved with California's child welfare services (CWS);

- To make an initial assessment of the possibilities for data integration and shared data management between CDE and CDSS.

Although there are numerous outcome areas covered by CDSS's child well-being indicators, those related to education can be categorized as follows:

- School Enrollment
    % of school aged children enrolled within 1, 2, 3, and 4 weeks of initial out-of-home placement
    % of school aged children enrolled within 1, 2, 3, and 4 weeks of a placement change
    % enrolled in non-public schools

- School Stability
    % with school change during the year
    # of school changes

% of children enrolled in the same school (as prior to entering care)

- School Attendance
    - % of children with adequate yearly attendance
    - # of school days missed

- Special Education and Related Services
    - % of children with an Individualized Education Plan (IEP)
    - Of children with an IEP, % who received services
- School Performance
    - % of children in care at grade level on standardized state tests, stratified by special and regular education
    - % of children performing below grade level

- Higher Education
    - % with a high school diploma or GED
    - % enrolled in college or higher education program
    - % who complete vocational training program

Overview of Findings

Although a more detailed analysis of both CDE and CDSS databases would be needed to provide definitive answers on the possibility of data integration, the current report provides a general overview of findings. This includes a brief description of findings for each outcome area covered by CDSS's education-related well-being indicators.

As noted earlier, the well-being indicators of primary relevance to CDE cover several key areas:
- School Enrollment
- School Stability
- School Attendance
- Special Education
- School Performance
- Higher Education

Findings will be organized according to each of these areas of interest.

School Enrollment

Data most relevant to school enrollment are maintained by the *California School Information Services (CSIS) Program*, a 1997 legislative initiative charged with developing and implementing an electronic statewide school information system. CSIS is designed to facilitate the exchange of student data between participating local educational agencies (LEAs), as well as the reporting of student information to CDE.

One of the data products maintained by the CSIS is the *Student Locator Database*, a demographic database used to issue a Statewide Student Identifier (SSID) to all public school students. CPPR

has determined that student-level enrollment data are available from the *Student Locator Database*, but that those data are only reported to CDE once per academic year (October). As a result, the data may be of limited usefulness to CDSS. CDE and CPPR representatives have determined that neither CDE nor individual LEAs collect enrollment information at fine enough intervals (i.e., with great enough frequency) to determine enrollment within 1, 2, 3, or 4 weeks of placement or placement change.

CDE does not maintain enrollment data from non-public schools. Although some information is reported on non-public school students (particularly eligible immigrant students and students who were referred by public schools), those data are most often aggregated to the school level.

School Stability
There is a possibility that a single school change within an academic year could be tracked using a combination of fall enrollment data (from the *Student Locator Database*) and information from CDE's standardized testing databases (some of which include data elements to identify the school in which the test was taken). However, the data would only allow for a determination of whether or not a student remained in the same school from fall to spring. The number of changes could not be determined. In addition, many students who have Individualized Education Plans (IEPs) are exempt from standardized testing.

CDE representatives also noted that the indicator addressing whether a child is enrolled in the same school before and after initial out-of-home placement could be addressed on the condition that CDSS could accurately identify the school in which the child was enrolled immediately prior to placement.

School Attendance
School attendance data are not available at the state level. CDE representatives also noted that the department does not have uniform definitions of adequate daily attendance (ADA) nor of truancy.

Special Education and Related Services
Identification of students with IEPs is possible through the *California Special Education Management Information System (CASEMIS)*. This database contains student-level data on demographics, types of services and providers, and program exit. Data are limited to those individuals between the ages of zero and 22 years of age receiving special education or related services. LEAs submit these data through their state education local plan area (SELPA) office.

The determination of which particular data elements within CASEMIS are of greatest interest is contingent upon CDSS identifying the specific IEP-related services they are interested in tracking.

School Performance
In the spring of each academic year, CDE requires its public schools to give a set of tests to all students in grades 2–11. These tests are part of the *Standardized Testing and Reporting* (STAR) program, which maintains extensive student-level data and testing results. Although some of the test questions measure students' mastery of basic skills, their main purpose is to see how well schools are teaching and students are learning the state's academic content standards in four core subjects: English-language arts, mathematics, science, and history/social science. STAR encompasses three different kinds of tests:

- CSTs (California Standards Tests), which are based on the state's standards—what students are supposed to know and be able to do at each grade level;

- CAT/6 (California Achievement Test, Sixth Edition), a test of basic skills;

- SABE/2 (Spanish Assessment of Basic Education, Second Edition), an additional test that native Spanish speakers take during their first year in California public schools.

Student-level results on these standardized tests are maintained in separate CDE databases, the majority of which include a data element for SSID. The question of which particular data elements are of interest is contingent upon CDSS determining (perhaps with the assistance of CDE representatives) which tests, composites, or norm-referenced results are most suited to the intent of the indicator.

Higher Education
CDE does not collect data from institutions of higher education (e.g., colleges, universities, or vocational schools). The California State University system may begin reporting some data to CDE in the future, but the University of California system has no plans to participate at this time.

Data on high school completion is available through CDE's *California High School Exit Exam (CAHSEE)Annual Detail Data Collection*. The associated database contains student-level high school exit exam information (including test scores), as well as information on the student, school, district, and county in which the test was taken.

Data on GED receipt are available through CDE's *General Educational Development (GED) Data Collection*. The associated database consists of records of individuals who have completed the test of GED in the state of California, as well as the date and location of testing, test scores, and student-identifying information. This database does not, however, include a data element for SSID.

Challenges/Limitations
In addition to gathering basic information on the existence of various databases and data elements, several important challenges to potential data integration between CDSS and CDE were discussed. These challenges/limitations can be broken down into several broad categories.

Reliability

Although questions of reliability will ultimately need to be assessed on a variable-by-variable basis, several general comments can be made about the quality of the data collected and maintained by CDE.

CDE reports that the majority of data quality issues are resolved at the local level, so that the data are assumed to be valid and free of major errors by the time they arrive at CDE. At the district level, some data are edited using a Visual Basic module that categorizes errors into those that are material, immaterial, or fatal (i.e., need to be resolved). Districts must resolve major errors and pass validation tests before transmitting their data to CDE. In addition to Visual Basic, other data quality technologies in use at the local and district levels are SQL Server stored procedures and various data checking procedures available through statistical software (SAS, SPSS, etc.)

Matching Issues

The primary means by which CDE identifies and tracks individuals within its data systems is through a unique student identification number. CDE does not maintain social security number in any of its data systems. Students in non-public schools do not have state-issued student IDs, as each school has its own system of ID assignment and student identification.

As an alternative to matching through a unique identifier, however, CDE acknowledged that their data systems do contain a range of demographic variables (such as name, gender, date of birth, and address) that could be used for the purpose of probabilistic matching. In cases of large administrative datasets, probabilistic matching is most often accomplished by the creation of executable algorithms within statistical software programs (e.g., SAS, SPSS). It should be noted, however, that matching data in this manner is challenging and often requires additional "hand matching" to ensure accuracy (i.e., locating or reviewing matches record-by-record). Such hand matching requires a great deal of time and human resources, particularly when dealing with large datasets.

Confidentiality/FERPA Issues

The Family Education Rights and Privacy Act of 1974, commonly known as FERPA, is a federal law that protects the privacy of student education records. Any record that contains personally identifiable information that is directly related to the student is an educational record under FERPA. The exchange of such information, therefore, would need to adhere to the guidelines set out in law.

In discussing FERPA issues with CDE representatives, several preliminary conclusions were drawn: (1) that the privacy of student educational records is of great importance to CDE; (2) that CDE is willing to work within FERPA guidelines to facilitate the exchange of information with CDSS; (3) that CDE has successfully exchanged student-level data with other California state agencies in the past; and (4) that data integration and exchange could likely be accomplished in several ways, including in-house exchange (i.e., data integration and de-identification within

CDE), under contract, or through the use of a Memo of Understanding (MOU) between CDE and CDSS.

Conclusions

To summarize, CPPR's initial assessment of the availability of CDE data related to CDSS's well-being indicators is as follows:

Table 1. Summary of CDE Findings

Indicator	Data Within CDE	Alternative Locations	Limitations
School Enrollment	No	CWS/CMS or local level	
School Stability	Partially – Student Locator Database and spring STAR data	CWS/CMS or local level	Would require combining fall enrollment data and spring standardized testing data. Could only determine *zero* versus *any* school changes within a given academic year .
School Attendance	No	CWS/CMS or school level	
Special education and related services	Yes - CASEMIS		Requires the identification of which particular IEP-related services are of interest to CDSS.
School Performance	Yes – STAR program data		Many students are exempt from standardized testing based on the conditions of their IEP.
Higher Education	Partially – CAHSEE and GED database	Institutional level or survey	

STATE INTERAGENCY TEAM (SIT)

Initial Findings from the California Department of Developmental Services

On June 12, 2006, a meeting took place between Center for Public Policy and Research (CPPR) staff and representatives from the California Department of Developmental Services (DDS). Attendees from each agency were as follows:

Center for Public Policy Research
Gail S. Goodman, CPPR Director/PI
Michael Lawler, CPPR Co-PI
Kate Wilson, Research Writer
Christin Ogle, Research Analyst
Joshua McCabe, Administrative Assistant

Department of Developmental Services
Sue Boucher, Manager, Training and Data Services
Marjorie Mar Lui, Information Systems Analyst/Data Extraction
Paul Choate, Lead Programmer Analyst/Data Extraction
Cheryl Haviland, Information Systems Analyst/Data Extraction

The primary purpose of this initial meeting was for CPPR to gather information on DDS data systems, specifically databases containing information relevant to the AB636 child well-being indicators proposed by the California Department of Social Services (CDSS) for use in their federally mandated *Child and Family Services Review* (CFSR). CPPR's goals for this meeting were:

- To identify information available on AB636-related issues, particularly those related to developmental and support services for children and parents involved with California's child welfare services (CWS);

- To make an initial assessment of the possibilities for data integration and shared data management between DDS and CDSS.

Overview of Findings
Although a more detailed analysis of the DDS databases would be needed to provide definitive answers on the possibility of data integration, the current report provides a general overview of the findings. Of the numerous outcome areas covered by CDSS's child well-being indicators, it was anticipated that DDS data could be relevant to indicators dealing with general health, mental health, and support services. Given these broad possibilities, the current report is structured around DDS data systems rather than around the indicators themselves.

The following are brief descriptions of five data systems maintained by DDS. Data from each of these databases are extracted monthly and maintained at the Health and Human Services Data Center. Note: Descriptions have been adapted from the document, *Information Resources*

Available at Department of Developmental Services, which was provided to CPPR by DDS, and from the *Department of Developmental Series: Fact Book* (8th Ed.).

Client Master File (CMF)
The Client Master File (CMF) contains demographic, case status, and service coordinator information on all persons who have applied for services provided by DDS, including those actively being served. The CMF is also used to match eligible clients with services provided using the Purchase of Service data system (see below). CMF data are initially collected at the 21 DDS Regional Centers and are updated annually or more frequently as needed.

The case files of all persons in the CMF database who are eligible to receive DDS services are classified by one of the following three active status codes:
> Status Code 1. Children birth to age 3 who are at risk of having a developmental disability or who have a developmental delay but have not been diagnosed as having a developmental disability. Persons with Status Code 1 qualify for early intervention and prevention services.
> Status Code 2. Persons diagnosed as having a developmental disability and being served in the community.
> Status Code 8. Persons diagnosed as having a developmental disability and being served in a State Developmental Center (SDC).

Several data elements within the CMF data system were determined as potentially useful in identifying AB636 children in the DDS data system: Residence Type, Legal Status, and Case Management Code. The CMF may also contain data on medications; however, the nature and reliability of these data must be further determined.

Client Development Evaluation Report (CDER)
The Client Development Evaluation Report (CDER) contains disability diagnosis and functioning evaluation information for all active clients over the age of three in the DDS system with a diagnosed developmental disability. The CDER is divided into two major sections, the Diagnostic Element and the Evaluation Element. The Diagnostic Element contains information pertaining to the individual's developmental disability(ies), mental disorders, risk factors, major medical conditions, hearing and vision impairments, behavior modifying drugs, special health care requirements, and other special conditions. The Evaluation Element includes information relating to motor, inde pendent living, social, emotional, cognitive, and communication skills.

CDER data are collected by the regional centers, or by SDCs (for individuals residing at an SDC). A CDER is completed or updated at the time a client's Individual Program Plan (IPP) is developed. A new IPP (and thus an updated CDER) is required at least once every three years. The CDER is also updated whenever there is a significant change in a client's physical or mental capabilities.

Two data elements within the CDER data system were identified as potentially useful in identifying AB636 children in the DDS data system: Current Residence and Legal Status. In addition, CPPR determined that data elements related to Behavioral Medications and Preferred Service Programs may be used to address the following CDSS child well-being indicators:

- Percent of parents able to access and use support services identified in case plans;

- Percent of children in care with CHDP exams, dental exams, psychotropic medications, and immunizations that comply with the periodicity table.

DDS representatives noted that the CDER instrument would eventually include more well-being information on eligible clients in the DDS system. The CDER also has self-report data relevant to children on probation; however, the nature of these data must be further explored.

Early Start Report System (ESR)
The Early Start Report System (ESR) contains demographic, diagnostic, developmental, behavioral assessment, and service information for clients in the DDS system younger than 36 months. The ESR is similar to the CDER instrument but contains data items that are more appropriate for infants and toddlers. The ESR system is updated annually or more frequently as needed.

CPPR determined that ESR data elements that are related to Medical Assessments and Consultations Services may be used to address the following CDSS child well-being indicators:

- Percent of parents able to access and use support services identified in case plans;

- Percent of children in care with CHDP exams, dental exams, psychotropic medications, and immunizations that comply with the periodicity table.

Purchase of Service System (POS)

The Purchase of Service (POS) System includes authorization information on all clients and contract services claims (e.g., service code, vendor, claim amount) as specified in clients' Individual Program Plan (IPP) or their Individualized Family Service Plan (IFSP). CPPR determined that data contained in the POS database might be relevant to the following CDSS child well-being indicators:

- Percent of parents able to access and use support services identified in case plans;
- Percent of CWS children with mental health referrals who receive mental health services.

Contained within the POS database are client and service claim information for 149 service types. Service types identified as potentially relevant to the aforementioned child well-being indicators can be summarized by the following broad categories:

- <u>Out-of-Home Care</u> – supervision and training for individuals in community care facilities;
- <u>Day Programs</u> – community-based training programs (e.g., behavior management, self-help/self-care skills, community integration, and infant development programs);
- <u>Non-Medical Services</u> – professional services including tutors, special education teachers, recreational therapists, counselors, infant development specialists, and speech pathologists;
- <u>Non-Medical Service Programs</u> – program services including parenting support services, client/parent support behavior intervention training, socialization training program;
- <u>Transportation</u> – transportation provided by transportation companies, residential facilities, day programs, public transportation, family members, friends, or ambulances;
- <u>Prevention Services</u> - services including infant development specialist, nurse's aide or assistant, and public school early intervention program.

One challenge to addressing the child well-being indicators with data from the POS system is that DDS Regional Centers can submit purchase of service claims to DDS several years after the services have been delivered. As a result, the POS database is subject to change as additional vendor billings are received by DDS for services delivered during previous years. Accordingly, the POS database may not reflect a complete record of services delivered to a particular client, but rather a record of service claims received by DDS for that client.

That DDS is a payor of last resort poses an additional challenge to addressing the child well-being indicators using POS data. DDS is required by law to provide or secure services in the most cost-efficient way possible. DDS must therefore use all other available resources, including those provided by other public or private agencies, before using DDS funds. Many of the services offered by DDS (e.g., transportation) to the eligible population are available through alternative organizations (e.g., public schools). As a result, the data maintained by DDS on services provided are not a complete record of the services received by the department's service population. Additional agencies will need to be consulted to identify services received through sources other than DDS.

Vendor System

The Vendor System includes information for all DDS service providers.

Challenges/Limitations
In addition to gathering basic information on the existence of various databases and data elements, several important challenges to potential data integration between CDSS and DDS were discussed. These challenges/limitations can be broken down into several broad categories.

Reliability

Although questions of reliability will ultimately need to be assessed on a variable-by-variable basis, several general comments can be made about the quality of the data collected and maintained by DDS. As with other departments, the reliability of the data in the DDS databases depends on the quality of data as entered by individual case workers at the 21 Regional Centers. Given that the Regional Centers have their own policies and procedures regarding data entry (e.g., frequency, completeness), the reliability of the data likely varies across Regional Centers. Another challenge to obtaining sufficient reliability of DDS data is that the electronic databases in which case workers enter their data contain many data elements that are optional, rather than mandatory (e.g., diagnosis). Thus, the data for these data elements are likely incomplete and biased by unknown factors.

Matching Issues

The primary means by which DDS identifies and tracks individuals within its data systems is through use of a seven-digit Unique Client Identifiers (UCI). Four of the five DDS databases use the UCI, with the exception of the Vendor File, which links to the POS data system using a Vendor ID. DDS also maintains SSN and medical number for the percentage of their service population with medical waivers (approximately 66%). In addition, DDS conducts a monthly data match between CIN, SSN, and UCI on individuals who are eligible for DDS services.

DDS data systems also contain a range of demographic variables (e.g., name, gender, date of birth, mother's name, and address) that could be used for probabilistic matching. In cases of large administrative datasets, probabilistic matching is most often accomplished by the creation of executable algorithms within statistical software programs (e.g., SAS, SPSS). It should be noted, however, that matching data in this manner is challenging and often requires additional "hand matching" to ensure accuracy (i.e., locating or reviewing matches record-by-record). Hand matching requires a great deal of time and human resources, particularly when dealing with large datasets.

Confidentiality/HIPAA Issues

DDS is a covered entity under the 1996 *Health Insurance Portability and Accountability Act (HIPAA)*, while CDSS is not. Although this limits the type of individual-level data that DDS may provide to CDSS, DDS noted that the department has participated in data-matching efforts with CDSS for the in-home support services population in the past. This suggests that HIPAA may not be a major obstacle to data sharing with DDS.

STATE INTERAGENCY TEAM (SIT)

Initial Findings from the California Department of Alcohol and Drug Programs

On July 11, 2006, a meeting took place between Center for Public Policy and Research (CPPR) staff and representatives from the California Department of Alcohol and Drug Programs (ADP). Attendees from each agency were as follows:

Center for Public Policy Research
Gail S. Goodman, CPPR Director/PI
Kate Wilson, Research Writer
Gary Stockdale, Quantitative Analyst
Joshua McCabe, Administrative Assistant

Department of Alcohol and Drug Programs
Tom Leigh, OARA CalOMS Liaison
Mahnaz Dashti, CalOMS Liason
Katrina Parker, Research Specialist
John Igwe, Data Requests
Craig Chaffee, Prop 36 Supervisor

The primary purpose of this initial meeting was for CPPR to gather information on ADP data systems, specifically databases containing information relevant to the AB636 child well-being indicators proposed by CDSS for use in their federally mandated *Child and Family Services Review* (CFSR). CPPR's goals for this meeting were as follows:

- To identify information available on AB636 issues, particularly those related to substance abuse treatment services for biological parents involved with California's child welfare services (CWS);
- To make an initial assessment of the possibilities for data integration and shared data management between ADP and CDSS.

Overview of Findings
Of the numerous outcome areas covered by CDSS's child well-being indicators, it was anticipated that ADP data could be relevant to the indicator specifying the availability and use of support services indicated in CWS case plans. Given this narrow applicability, the current report is structured around ADP's sole state-level database rather than around the indicators themselves.

CalOMS
The California Outcomes Measurement System (CalOMS) is a statewide client-based data collection process and associated database. The CalOMS system was launched in January of

2006, replacing ADP's previous database, the California Alcohol and Drug Data System (CADDS). CalOMS is designed to allow ADP to effectively manage and improve the provision of alcohol and other drug services at the state, county, and provider levels.

CalOMS treatment data collection is required from all providers licensed for narcotic replacement therapy and all providers receiving ADP funding for clients receiving the following services:

Non-residential/Outpatient Services:
- Outpatient drug free
- Day care rehabilitative
- Detoxification (non-medical)
- Narcotic treatment – maintenance
- Narcotic treatment – detoxification

Residential Services:
- Detoxification (hospital)
- Detoxification (non-hospital)
- Treatment / recovery (30 days or less)
- Treatment / recovery (30 days or more).

Providers are required to collect client data at admission, as well as at discharge or administrative discharge from the same treatment program. CalOMS data are also collected annually as an update for clients formerly in treatment for a period greater than 12 months.

Any provider who receives public funding for treatment services and all Narcotic Treatment Program (NTP) providers must report CalOMS data for all clients receiving treatment, whether those individual client services are funded by public funds or not. An exemption exists for providers who receive funds under the Substance Abuse Crime Prevention Act (SACPA) only. A treatment provider who falls into this category must collect and report CalOMS data only for the clients who are funded through SACPA. They are not required to report CalOMS data for their other clients.

Any treatment service provider who does not receive public funding does not report data to ADP.

CalOMS data are sent to ADP monthly in batch files from counties and, in some cases, from direct providers. Files are then uploaded into the CalOMS system.

Variables
The CalOMS dataset contains 13 variables related to personal identification. These include standard demographic variables (first and last name, gender, date of birth, race/ethnicity), as well as data elements for social security number, zip code, driver's license number, and mother's first name.

ADP representatives reported that these demographic and personal variables have a high degree of reliability and are well-populated in the database. Reliability will be further discussed in the Challenges/Limitations section (p. 3).

In addition to these variables, CalOMS contains four variables that might be useful in identifying CWS clients. Providers reporting to ADP are required to ask clients:

(1) the number of children they have who are aged 17 or less (with the specification "whether they live with you or not");

(2) the number of children they have who are aged 5 or younger;

(3) the number of children they have who are living with someone else because of a child protection court order; and

(4) the number of children (of those living with someone else because of a child protection order) for whom parental rights have been terminated.

CPPR and ADP representatives felt that some or all of these variables could be useful in the identification of CWS clients in ADP data systems, either alone or as part of a probabilistic matching algorithm.

In terms of the specific areas of interest to CDSS's child well-being indicators, the receipt of substance abuse treatment services may well be applicable to the needs of biological parents identified in CWS case plans. For example, treatment services may be indicated as part of a family's overall reunification plan. In such cases, treatment services may well fall under the category of "support services", which are relevant to well-being indicator 7(a):

% of parents able to access and use support services identified in case plans.

Challenges/Limitations
In addition to gathering basic information on the existence of various databases and data elements, several important challenges to potential data integration between CDSS and ADP were discussed. These challenges/limitations can be broken down into two broad categories.

Reliability
Although ADP representatives were unable to quantify reliability at this time, they did feel that the new CalOMS system is robust. Data must have a certain degree of integrity before being sent up from counties and providers. For example, null values are not allowed for the majority of variables.

ADP representatives were not certain, however, as to the degree of validity checking that may or may not occur at the county level. For this reason, incorrect or dummy social security numbers may exist in the system. In addition, clients entering substance abuse treatment may be reluctant to answer many of the questions related to CalOMS data elements.

That said, ADP staff were confident that CalOMS data could prove useful to CDSS and would have decidedly sufficient reliability for the purposes of probabilistic matching and client identification.

Confidentiality Issues

One of the greatest challenges to the sharing of ADP data is confidentiality. Due to the nature of the services recorded in CalOMS, the data are subject to both Health Insurance Portability & Accountability Act (HIPAA) protections and the protections afforded under the Code of Federal Regulations (CFR). Specifically, the vast majority of CalOMS data are protected by 42CFR, Part 2, which relates to alcohol and drug abuse patient records.

That said, it may be possible to work within HIPAA and CFR guidelines. For example, CDSS could provide ADP with a list of clients of interest, after which ADP could (1) identify such individuals within their data system via probabilistic matching on demographic variables, (2) de-identify the matched data using a unique numerical code, and (3) provide CDSS with a new data file containing individual-level data listed by these new codes.

Additional Information

It should also be noted that, in addition to their willingness to cooperate with CDSS on their current AB636 efforts, ADP representatives also expressed an interest in CDSS data. ADP staff stated that there are several topic areas related to CDSS clients, programs, and services that are of great interest to their organization.

For this reason, data sharing and data integration may prove beneficial to both agencies, and ADP was eager to open initial discussions with CDSS toward these ends.

STATE INTERAGENCY TEAM (SIT)

Initial Findings from the California Department of Health Services

On July 20, 2006, a meeting took place between Center for Public Policy and Research (CPPR) staff and representatives from the California Department of Health Services (DHS). Attendees from each agency were as follows:

Center for Public Policy Research
Gail S. Goodman, CPPR Director/PI
Kate Wilson, Research Writer
Christin Ogle, Research Analyst
Joshua McCabe, Administrative Assistant

Department of Health Services
Lester Newman, Maternal, Child and Adolescent Health/Office of Family Planning Branch
Eugene Takahashi, MCAH/OFP Branch
David Dodds, MCAH/OFP Branch

The primary purpose of this initial meeting was for CPPR to gather information on DHS data systems, specifically databases containing information relevant to the AB636 child well-being indicators proposed by the California Department of Social Services (CDSS) for use in their federally mandated *Child and Family Services Review* (CFSR). CPPR's goals for this meeting were:

- To identify information available on AB636-related issues, particularly those related to developmental and support services for children and parents involved with California's child welfare services (CWS);
- To make an initial assessment of the possibilities for data integration and shared data management between DDS and CDSS.

Although there are numerous outcome areas covered by CDSS's child well-being indicators, those related to health can be categorized as follows:

5A	% of children in care more than 30 days with a Health Passport
5B	% of children in care with CHDP that comply with periodicity table
	% of children in care with dental exams that comply with periodicity table
	% of children in care with psychotropic medication consultations
	% of children in care with immunizations that comply with periodicity table
5C	% of CWS children with mental health referrals who receive mental health services, stratified by in-home vs. out-of-home care
5D	Family maintenance children receive Health Passports and screenings
5E	% of children in care who receive an initial mental health screening within 30 days of initial placements

Overview of Findings

Although a more detailed analysis of the DHS databases would be needed to provide definitive answers on the possibility of data integration, the current report provides a general overview of the findings.

The majority of the datasets maintained by DHS are related to, or are subsets of, the population covered by the Medi-Cal Eligibility Data System (MEDS). MEDS is a statewide dataset administered by DHS and developed from the federal government's design for a model Medicaid Management Information System (MMIS). MEDS maintains a record for every individual who has been reported as Medi-Cal eligible since MEDS implementation began in 1981. Each county regularly sends to MEDS information from its individual data systems about Temporary Assistance for Needy Families (TANF) recipients, primarily so MEDS can produce Medi-Cal cards. The information maintained on MEDS comes from counties, federal agencies, DHS, and other sources (e.g., private health care plans). MEDS is generally used for managing the issuance of Medi-Cal cards, tracking enrollment in other health insurance programs, and processing claims.

The data available on MEDS include Medi-Cal program participation, county of residence, Medi-Cal Share of Cost, provider type, and health insurance information for all Medi-Cal recipients. For TANF recipients, MEDS records indicate the TANF program code for each month and contain other demographic information. The eligibility file on MEDS is a individual-based system, and the primary identifier used to locate individuals in the system is the individual Medicaid recipient's Social Security number. Also available are the name, date of birth, address, race, and gender of each individual, and the individual's TANF case number or SSI case number, if they are using one of those programs. A ten-digit space is available for the recipient's public assistance case number. Every TANF recipient has a seven-digit TANF serial number assigned by the county. Two digits contain the county code and one digit indicates if the individual is in one of multiple assistance units within the case. All individuals in an TANF case can be pulled together through their common case number, and this number, combined with the county code, is unique throughout the state.

Looking specifically at the health-related indicators, 5A and 5D involve the timely receipt of Health and Education Passports (HEP). HEPs are designed to maintain a detailed summary of all CWS children's health and education information, consistent with the Welfare and Institutions Code Section 16010. Currently, this document is maintained by CDSS and linked to the data entered by case workers into an individual child's CWS/CMS case plan. Given this, CPPR was advised by its primary CDSS contact to disregard these indicators when conducting its informational meetings with the DHS, as the information needed to address them can (and can exclusively) be extracted from the CWS/CMS system and/or hard copies of the child's case file.

Next, the four measures constituting well-being indicator 5B involve the receipt of various health services, including the initial *Child Heath and Disability Prevention* (CHDP) screenings CWS children are mandated to receive within 30 days of out-of-home-placement. CHDP preventive health assessments are provided through a range of health care providers, including private physicians, local health departments, schools, nurse practitioners, dentists, health educators, nutritionists, laboratories, community clinics, nonprofit health agencies, and social and community service agencies. The following services are provided by the CHDP program:

- Health and developmental history
- Complete physical examination
- Oral health assessment
- Nutritional assessment
- Behavioral assessment
- Immunizations as appropriate for age
- Vision screening
- Hearing screening
- Screening tests for anemia, blood lead, tuberculosis, urine abnormalities, sexually transmitted diseases, and other problems as needed
- Health education and anticipatory guidance

CHDP data are maintained by the CHDP program, which is administratively housed within DHS. In addition, all CHDP providers are required to forward CHDP data back to the child's caseworker via a hard copy of the CHDP PM 160 form. The data from these forms, which are typically completed by public health nurses or the providers themselves, are also entered into a database maintained by the CHDP program. Those data then move through a fiscal intermediary and into the larger MEDS database maintained by DHS.

Given that indicator 5B reflects both CHDP screenings and the specific services that constitute them (dental exams, vision screenings, and immunizations), the data related to all aspects of this indicator are most likely to reside in DHS data systems. During and subsequent to CPPR's meeting with DHS, agency representatives did not provide specific information on the reliability of these data, the timeliness of its eventual transfer into the MEDS database, nor information on the specific variables related to screening and exam types. DHS representatives did confirm, however, that all available data related to the CHDP program are accessible through their department. In addition, DHS informed CPPR that—although there are additional, regional immunizations registries—the data within these registries is voluntarily reported and incomplete. DHS representatives noted, however, that all immunization information listed on the CHDP PM 160 forms is returned to a child's caseworker.

As reported in CPPR's individual report for the Department of Mental Health (DMH), representatives from the agency reported that data related to mental health screenings and mental health referrals are not maintained by their department, but may be available from county mental health organizations. Given that mental health screenings (and the referrals they generate) take place as part of CHDP exams, it is possible that this information can also be

extracted from CHDP or MEDS. If screenings and referrals that take place outside the CHDP programs are of interest, the data needed to thoroughly address these indicators would be extremely difficult to locate. Although the majority of CWS foster children are likely to bill for such services through Medi-Cal (due to their Title IVE eligibility), private pay visits may also occur. In addition, many services that could be considered mental health screenings and referrals may occur during more comprehensive visits with a pediatrician or family practice doctor, and would therefore not appear in the MEDS database as a mental health provider contact.

Recommendations

In terms of the Core Indicator Workgroup's interest in cross agency data sharing, it should be noted that DHS expressed a great deal of interest in working with CDSS, not only in relation to CWS children, but to the broader population of Californians served by both departments.

Short of such future collaborations between the two departments, it was DHS's express recommendation that CDSS go through the DHS formal data request process in order to address well-being indicators 5B, 5C, and 5E. Such requests go through DHS's Center for Health Statistics (CHS), which not only facilitates the collection, validation, statistical analysis, and dissemination of health data in support of DHS's mission, but is also responsible for providing technical assistance relating to vital statistics data to users external to DHS (local government, academia, researchers, the general public, etc.) The CHS is comprised of the Office of Vital Records (OVR), the Office of Health Information and Research (OHIR), the Administration Support Section, and the Information Technology Services Section (ITSS).

Specific data requests by CDSS to the CHS could occur one of two ways: CHS staff could identify foster care children within the MEDS database using foster care eligibility aid codes, or CDSS could provide CHS with a list of the social security numbers of their population of interest and CHS could work to locate those individuals within their system. In either scenario, CHS data experts could work to extract all paid claims related to health and mental health services provided through CHDP or paid for through Medi-Cal. If given specific research questions (i.e., operationalized versions of the indicators), CHS could provide CDSS with answers to their questions rather than providing the actual data. Taking this approach would also nullify concerns over HIPAA regulations and confidentiality in that the DHS would not actually be releasing personal health information (PHI) to an outside entity.

Future plans for requesting health data will also need to include the planned reorganization of DHS into two departments, effective July 1, 2007. The California Department of Public Health (CDPH) will include the Center for Health Statistics. The Department of Health Care Services (DHCS) will include Medi-Cal and Children's Medical Services (CMS).

Table 1 (next page) provides indicator-by-indicator findings related to DHS data systems.

Table 1. Summary of DHS Findings

Indicator	Data Within DHS	Alternative Locations	Limitations
HEPs	No	CWS/CMS	
CHDP Exams	Yes	CWS/CMS	Utilizing DHS's data request procedures
Dental Exams	Yes	CWS/CMS	Utilizing DHS's data request procedures
Psychotropic Medication Consultations	Yes	CWS/CMS	Utilizing DHS's data request procedures; would not include consultations that took place outside CHDP program
Vision Exams	Yes	CWS/CMS	Utilizing DHS's data request procedures
Immunizations	Yes	CWS/CMS	Utilizing DHS's data request procedures; would only include immunizations that are formally noted or received through the CHDP
Mental Health Screenings	Yes	CWS/CMS	Utilizing DHS's data request procedures
Mental Health Services	Yes	CWS/CMS	Utilizing DHS's data request procedures; conditional nature of the indicator (ability to tie services to referrals)

STATE INTERAGENCY TEAM (SIT)

Initial Findings from the California Administrative Office of the Courts

On July 21, 2006, a telephone meeting took place between Center for Public Policy and Research (CPPR) staff and a representative from the California Administrative Office of the Courts (AOC). Participants from each agency were as follows:

> Center for Public Policy Research
> Gail S. Goodman, CPPR Director/PI
> Michael Lawler, CPPR Co-PI
> Kate Wilson, Research Writer
> Gary Stockdale, Quantitative Analyst
> Joshua McCabe, Administrative Assistant

> Administrative Office of the Courts
> Don Will, Supervising Research Analyst, Center for Families, Children & the Courts

The primary purpose of this meeting was for CPPR to gather information on AOC data systems, specifically databases containing information relevant to the AB636 child well-being indicators proposed by CDSS for use in their federally mandated *Child and Family Services Review* (CFSR).

It was anticipated that four of the fifteen indicators could be relevant to AOC:
    Of youth exiting from foster care:
        % with a legal emancipation hearing or termination of jurisdiction hearing
        % with the documents required by AB 686
    Of youth in foster care:
        % who are on probation or incarcerated
        % who are transferred into the juvenile justice system

Overview of AOC

The Administrative Office of the Courts (AOC) is the staff agency to the Judicial Council of California, the policymaking body of the state court system. The AOC is responsible for a variety of programs and services, and is organized into: nine divisions in San Francisco, one division in Sacramento, and three regional offices. The AOC is organized based on functional responsibilities that are rooted in judicial administration and court operations areas. Although these responsibilities are carried out across the organization, certain roles and activities are department specific. One department of particular interest to CDSS's current project is the Center for Families, Children & the Courts (CFCC), whose mission is to improve the quality of services to families, children, and self-represented litigants in the California courts. Many of CFCC's projects relate to family, juvenile, child support, custody, visitation, and domestic violence law and procedure. The center also initiates projects involving issues of juvenile dependency, victim reconciliation, and court access.

Overview of the California Court System

To understand the movement and organization of court-related data, a basic understanding of the structure of the California court system is required. The vast majority of cases in the California courts begin in one of the 58 superior (or trial) courts, which reside in each of the state's 58 counties. With facilities in more than 450 locations, these courts hear both civil and criminal cases, as well as family, probate, and juvenile cases. The equivalent of more than 2,000 judicial positions address the full range of cases heard each year by the superior courts, as reflected in the sheer number of case filings and dispositions reported here. The trial courts report summaries of their case filing counts to the AOC.

The next level of judicial authority within the state's judicial branch resides with the Courts of Appeal. Most of the cases that come before the Courts of Appeal involve the review of a superior court decision that is being contested by a party to the case. The Legislature has divided the state geographically into six appellate districts, each containing a Court of Appeal. Currently, 105 appellate justices preside in nine locations in the state to hear matters brought for review. Totals of Court of Appeal case filings are also forwarded to the AO C.

Finally, the Supreme Court sits at the apex of the state's judicial system and may review decisions of the Courts of Appeal in order to settle important questions of law and ensure that the law is applied uniformly. The Supreme Court has considerable discretion in deciding which decisions to review, but it must review any case in which a trial court has imposed the death penalty. The Supreme Court sends the AOC its annual case filing figures.

All of the above court data reported to the AOC is summarized in AOC's annual *Court Statistics Report (CSR)*. The *CSR* combines 10-year statewide summaries of superior court filings and dispositions with similar workload indicators for the California Supreme Court and Courts of Appeal. The *CSR* also provides the statistical basis for many of the workload trends identified in the annual report. The CSR, however, is not designed as a case management or outcome measurement tool. Its purpose is to help fulfill the provisions of article VI, section 6 of the California Constitution, which requires the Judicial Council to survey the condition and business of the California courts.

Overview of Findings

Given the focus of the AOC on court-level descriptions and analyses, no individual-level data are reported to them, nor do they mandate such data be collected by the courts. For this reason, the AOC representative felt the data they maintain would be of limited usefulness in research related to CWS populations. CPPR and AOC representatives also explored the possibility that data of interest may be maintained by the courts themselves. Although the AOC representative felt that the courts may have data of interest, these data are unlikely to be accessible in electronic form. While it may be possible to cull information from court-level "paper" records, CDSS would be faced with the option of sampling from one or more superior courts, or dedicating a great deal of time and human resources to collecting data from all 58 superior

courts throughout the state. In addition, sampling from several courts may be problematic in that definitions are not standardized across courts, with courts in some cases displaying differences in how they define whether or not hearings of certain types took place.

The AOC is in the process of creating a standardized case management system for the California courts. The juvenile dependency and delinquency components of the California Case Management System (CCMS) are currently in development and will be deployed sometime in 2010. The California Blue Ribbon Commission on Children in Foster Care, which includes representation from CDSS and other agencies involved in the Core Indicators Project, is reviewing and recommending dependency court data elements and performance measures to be incorporated into the CCMS. The data reported by local courts to the AOC through CCMS will continue to be aggregate data, however CCMS will result in detailed, standardized case level data on dependency cases in each local court.

APPENDIX C

Roster for the Core Indicator Workgroup

Of the State Interagency Team

Roster for the Core Indicator Workgroup

Of the State Interagency Team

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